

295049

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 1 3 7

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) LOUIS U. ADKINS			2a. DATE OF DEATH MONTH DAY YEAR October 16, 1985		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 1, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Fullerton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5183 Terrace Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Fullerton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5183 Terrace Dr. 21236	
14. FATHER'S NAME FIRST MIDDLE LAST Alexander Adkins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-07-0159		17. INFORMANT ADDRESS M. Marie Adkins - Same as #13e	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Adeno Carcinoma of Lung

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH*2 years*PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *None*

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (we) hospital attended the deceased from <i>Nov 18</i> 19 <i>83</i> to <i>October 16</i> 19 <i>85</i> , that (I) (we) lost saw the deceased alive on <i>Sept. 4</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>L. Myrton Gaines, Jr.</i> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>10/16/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. Myrton Gaines, Jr.				22e. ADDRESS 7800 York Rd.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10-19-85	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith	23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.		25a. DATE REC'D. BY REGISTRAR OCT 18 1985	
ADDRESS 1050 York Rd. Towson, Md. 21204		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

CROSS



WINDMILL BRAND

100% COTTON FIBER

10/10/11

WINDMILL BRAND

303033

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 1 3 8

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Martin Adler			2a. DATE OF DEATH MONTH DAY YEAR 10-23-85 5:40 P. 1740 PM		
3. SEX male	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JAN-14-01	6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH RANDALLSTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balto. County General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BROKER	12b. KIND OF BUSINESS OR INDUSTRY STOCKS	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTO. 13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST PHILIP ADLER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA UNKNOWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 217-16-1387	17. INFORMANT MR. ALVIN M. BRAVERMAN 806 SMOKE TREE RD. BALTO., MD #21208		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Congestive HF failure.**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) **Left Pneumothorax**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Chr Brain Syndrome**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10-22 , 19 85 , to 10-23 , 19 85 , that (I) (we) last saw the deceased alive on 10-23 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (it) (did not) view the body after death.			
22b. SIGNATURE G. Rao	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 10-23-85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kayadberg G. Rao		22e. ADDRESS Balto. County Genl Hospital	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE OCT. 25, 1985	23c. NAME OF CEMETERY OR CREMATORY AITZ CHAIM	23d. LOCATION BALTIMORE COUNTY MARYLAND
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215		25a. DATE REC'D. BY REGISTRAR OCT 28 1985	25b. REGISTRAR'S SIGNATURE J. H. Swickard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be given to the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Miss. Madelina Aitt			2a. DATE OF DEATH MONTH DAY YEAR October 16 1985			2b. HOUR 7:30 M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR October 18 1890		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY) Stella Maris			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Defence Dept.		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Randallstown			
14. FATHER'S NAME FIRST MIDDLE LAST Mr. John Aitt				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Madelina Frankfurter					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-20-7489		17. Mr. Philip T. McCusker 16 S. Calvert Street		ADDRESS Baltimore Maryland 21202			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Chronic obstructive Lung disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10-10 , 19 80 , to 10-16 , 19 85 , that (I) (we) last saw the deceased alive on 10-16 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Eddie NaKhuda M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-16-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS 2300 Dulaney Valley Rd Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-18-85		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Maryland		
24. FUNERAL DIRECTOR Loring Byers Funeral Directors, Inc. NAME ADDRESS 8728 Liberty Road Randallstown, Maryland 21133						25a. DATE REC'D. BY REGISTRAR OCT 24 1985		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

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United States

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Mr. Robert E. Kennedy
16 E. (Silver Street)
Washington, D.C.

16 E. (Silver Street)

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Thelma I Albaugh			2a. DATE OF DEATH MONTH DAY YEAR 10-9-1985		2b. HOUR 2135 M	
3 SEX Female		4. RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR 2-10-1930		6 AGE (IN YEARS LAST BIRTHDAY) 55 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.
10. CITY OR TOWN OF DEATH RANDALISTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GENERAL Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Frederick		13c. CITY OR TOWN Frederick	
14 FATHER'S NAME FIRST MIDDLE LAST Harry Thomas Phelps			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Olive V. Atkins			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-44-4055		17 INFORMANT ADDRESS Fred. Md. 21701 Ernest W. Albaugh 9 Hillside Apt.	

18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prolonged Cerebral Anoxia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs
DUE TO, OR AS A CONSEQUENCE OF (b) CARDIOPULMONARY Arrest		
DUE TO, OR AS A CONSEQUENCE OF (c) ASPIRATION PNEUMONIA		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
Chronic Obstructive Pulmonary Disease with Chronic Hypercapnea

19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) NIA			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10-7-1985, to 10-9-1985, that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on 10-9-1985, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) (did not) view the body after death.							
22b. SIGNATURE Gary A. Manko MD				DEGREE MD		22c. DATE SIGNED 10-9-1985	
22d. PHYSICIAN (NAME (TYPE OR PRINT)) GARY A. MANKO MD				22e. ADDRESS 11 E. Chestnut Hill Ln, REISTERSTOWN, MD 21116			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10-19-85		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Smithsburg Washington Md	
24. FUNERAL DIRECTOR NAME G. Douglas Stauffer 1621 Opossumtown Pike, Fred. Md. 21701				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE OCT 15 1985			

BP

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

SECTION 2

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MAZIE L. ALDER				2a. DATE OF DEATH MONTH 10 DAY 21 YEAR 85				2b. HOUR 2A.M.	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH 8 DAY 5 YEAR 1900		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Lutherville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6 DUNWICH Rd 21093				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) th wife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE Md		13b. COUNTY Balto		13c. CITY OR TOWN Lutherville	
14. FATHER'S NAME FIRST MIDDLE LAST Joshua Lutz				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida L. Evans					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-74-7980		17. INFORMANT ADDRESS Mrs EVANS Daughter - same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic Cordis Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (b) C DUE TO, OR AS A CONSEQUENCE OF (c) 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH many yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes Mellitus, Hypertension, previous T.I.A.s									
19a. DATE OF OPERATION X N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> TO DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NO WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (as a hospital) attended the deceased from 5-1-69 , 19 85 , to 10-21 , 19 85 , that (we) last saw the deceased alive on 10-20 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) not view the body after death.									
22b. SIGNATURE John C. Hyle				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10-21-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN C. Hyle				22e. ADDRESS 7527 Belair Rd Balto 21236					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10-22-85		23c. NAME OF CEMETERY OR CREMATORY Westview		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.			
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204				ADDRESS 1050 York Rd.		25a. DATE REC'D. BY REGISTRAR OCT 24 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Rendall	

BP
DHMH - 16 60M 7/B4
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon pages 3 and 4. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 1 4 2

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) A Louise H Allen			2a. DATE OF DEATH MONTH DAY YEAR 10-7-85			2b. HOUR 1210P			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 10 21 20		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore City		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Car Baltimore County MD			
10. CITY OR TOWN OF DEATH Baltimore County		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Crossing Guard		12b. KIND OF BUSINESS OR INDUSTRY AA Co. P. D.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY AA		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7822 Oakwood Road 21061	
14. FATHER'S NAME FIRST MIDDLE LAST Peter R. Valeggie					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Puhlman				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-03-9755		17. INFORMANT ADDRESS Melvin G. Allen, Husband, same as 13					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Ca Brain

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**3 months**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 10-6-79 to 10-7-85 that (I) <input checked="" type="checkbox"/> saw the deceased alive on 10-7-85 and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above.							
22a. SIGNATURE MB Puhlman				DEGREE		22c. DATE SIGNED 10/7-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MB Puhlman				22e. ADDRESS 5400 O-C-D-ROAD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10 Oct. 1985		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, AA, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS James S. Kirkley, Glen Burnie, Maryland				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE OCT 9 1985			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained with 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

88718

10-1-82 (110)

W/11A

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10-1-82

PA

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CHIEF OF POLICE

203 COLLEGE AVE

295059

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN W. Armiger SR.			2a. DATE OF DEATH MONTH DAY YEAR 10 14 85		2b. HOUR 7:35 pM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR December 13, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER BALTIMORE MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney		12b. KIND OF BUSINESS OR INDUSTRY Law
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 30. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Cockeysville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Stephen Armiger		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Warfield			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 217-09-0481		17. INFORMANT ADDRESS John W. Armiger Jr. 1 Oakridge Ct. 21093	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ischemic coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (the hospital) attended the deceased from 10-4 , 19 85 , to 10-14 , 19 85 , that (I) (we) last saw the deceased alive on 10-14 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we) did not view the body after death.					
22b. SIGNATURE <i>R. Breitenecker</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-15-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rudiger Breitenecker, M.D.		22e. ADDRESS 6701 N. Charles Street, Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-17-85	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Lutherville Baltimore Maryland
24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home 6500 York Road 21212			25a. DATE REC'D. BY REGISTRAR OCT 18 1985		25b. REGISTRAR'S SIGNATURE <i>L. A. Kinsman</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 3 should be detached for use as the burial-transit permit. Page 4 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Page 4 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Page 4 may be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 1 4 4

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William Lee ARMSTRONG			2a. DATE OF DEATH MONTH DAY YEAR October 4, 1985		2b. HOUR 8:30 P.M.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 6, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Inspector-Gen. Motors		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Middle River		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1104 Susquehanna Ave. 21220	
14. FATHER'S NAME FIRST MIDDLE LAST William L. Armstrong				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Shaughnessy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-05-5090		17. INFORMANT ADDRESS Mrs. Helen A. Armstrong Same					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Recurrent pleural effusions</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <u>he</u> (this hospital) attended the deceased from <u>Sept. 9</u> , 19 <u>85</u> , to <u>Oct. 4</u> , 19 <u>85</u> , that <u>he</u> (we) lost <u>saw</u> the deceased alive on <u>Oct. 4</u> , 19 <u>85</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>he</u> (we) (did) <u>not</u> view the body after death.									
22b. SIGNATURE <u>Keith English</u> MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>10/4/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Keith English, MD				22e. ADDRESS 9000 Franklin Square Dr., 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 8, 1985		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc. Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR OCT 7 1985		25b. REGISTRAR'S SIGNATURE <u>James A. Henderson</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B as any injury, or other traumatic event, the attending physician should also complete item 21c.

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283136

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			20. DATE KNOWN OF DEATH			21. DATE OF DEATH			22. DATE OF DEATH			23. DATE OF DEATH			24. DATE OF DEATH		
ORLENA Ruth BAILEY			OCT 5 1985			OCT 5 1985			OCT 5 1985			OCT 5 1985			OCT 5 1985		
2. SEX FEMALE			3. RACE W			4. DATE OF BIRTH 5 - 2 - 16			5. AGE (IN YEARS) 69			6. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.			7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Clarksburg, W. Va. - U.S.A.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY			10. CITY OR TOWN OF DEATH TOWSON			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST JOSEPH HOSPITAL		
12. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE MD			12b. CITY OR TOWN Baltimore			12c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			12d. STREET ADDRESS 3616 ROBERTS PLACE			12e. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF LAST YEAR) HOMEMAKER			12f. KIND OF BUSINESS OR INDUSTRY Home		
13. FATHER'S NAME FIRST MIDDLE LAST Arlie ---- Smith			14. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Orlena ---- Wadsworth			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16. SOCIAL SECURITY NO. 173-18-5103			17. INFORMANT 3616 Roberts Place - Balto., Mr. Milton G. Bailey / Md. 21224.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>2 ± yr</u>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			22b. ACTUAL SIGNATURE <u>Richard P. Donnell</u> M.D. DEPUTY MEDICAL EXAMINER			22c. DATE SIGNED 10/5/85		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/10/85			23c. NAME OF CEMETERY OR CREMATORY Mountain View Mem. Park-Brownfield, Pa.			23d. LOCATION CITY OR TOWN Fayette County			24. FUNERAL DIRECTOR NAME John A. Moran, Inc. Funeral Home ADDRESS 3000 E. Baltimore St., Baltimore, Md. 21224			25. DATE REC'D. BY REGISTRAR OCT 8 1985		
25. REGISTRAR'S SIGNATURE <u>Richard P. Donnell</u>			26. REGISTRAR'S SIGNATURE <u>Richard P. Donnell</u>			27. REGISTRAR'S SIGNATURE <u>Richard P. Donnell</u>			28. REGISTRAR'S SIGNATURE <u>Richard P. Donnell</u>			29. REGISTRAR'S SIGNATURE <u>Richard P. Donnell</u>			30. REGISTRAR'S SIGNATURE <u>Richard P. Donnell</u>		

22133

BALTIMORE COUNTY

HOSPITAL

YOUNG

WYATT

MD

173-10-2101



302011

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8-5

27146

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JANE DEBORAH BARRATT BALFOUR			2a. DATE OF DEATH MONTH DAY YEAR 10 23 85			2b. HOUR 10 1/4 AM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 22, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		9b. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD					
11a. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Education/ Administration		12b. KIND OF BUSINESS OR INDUSTRY Nursing			
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10 Over Ridge Ct., 21210			
14. FATHER'S NAME FIRST MIDDLE LAST James Barratt				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Orr							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 34 7270		17. INFORMANT Charles E. Balfour, III,				ADDRESS MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Ischemic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <u>October 17</u> , 19 <u>85</u> , to <u>October 23</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>October 22</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Charles B. Hutton</u>				DEGREE MD				22c. DATE SIGNED 10/23/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES B. HUTTON MD				22e. ADDRESS 7600 OLIVE DE TOWSON, MD 21204							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/25/85		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge			23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, MD			
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. ADDRESS 4905 York Road Balto., MD 21212						25a. DATE REC'D. BY REGISTRAR OCT 25 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

MEDICAL CERTIFICATION

279

BP

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be completed within 24 hours after death. Pages 2 and 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, it should be so specified on page 3.

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John =

2018年12月25日

Handy W. Jones & Son, Inc.

[illegible]

Fiveville

2024-2025

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 1 4 7

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>William H. Bandell</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>Oct. 21 1985</i>		2b. HOUR <i>12 01 A.M.</i>	
3. SEX <i>Male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>9 15 00</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>85</i> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>TOWSON BALTO CO MD.</i>	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>St. Joseph Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Roofer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>

13a. STATE <i>MD</i>		13b. COUNTY <i>Balto.</i>	13c. CITY OR TOWN <i>Balto.</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>1720 Edgewood Rd 21234</i>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Leonard Bandell</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Helen Manner</i>			

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>	16b. SOCIAL SECURITY NO. <i>212-07-3384</i>	17. INFORMANT ADDRESS <i>MARY 1720 Edgewood Rd. 21234</i>
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18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute bronchopneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (the hospital) attended the deceased from <i>10-23</i> , 19 <i>85</i> , to <i>10-31</i> , 19 <i>85</i> , that (1) (the hospital) lost saw the deceased alive on <i>10/31</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.			
22b. SIGNATURE <i>Samuel C. H. Lee, M.D.</i>	DEGREE <i>M.D.</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>10/31/85</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>SAMUEL C. H. LEE, M.D.</i>		22e. ADDRESS <i>7620 YORK ROAD TOWSON MD 21204</i>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>11-4-85</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Balto. Cem.</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. Md.</i>
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24. FUNERAL DIRECTOR NAME ADDRESS <i>John C. Miller Inc. 6415 Belair Rd.</i>	25a. DATE REC'D. BY REGISTRAR <i>NOV 01 1985</i>	25b. REGISTRAR'S SIGNATURE <i>John C. Miller</i>
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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100% COTTON

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR				REG. NO.					
I. DECEASED NAME (TYPE OR PRINT)				7a. DATE OF DEATH				7b. HOUR	
PHILOMENE BARCHET				10 27 85				3:15 A.M.	
1. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		8. IF UNDER 1 YEAR	
Female		White		1 29 06		79 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Germany		U.S.				Baltimore County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YRS.)		12b. KIND OF BUSINESS OR INDUSTRY	
Catonsville		Frederick Villa Nurs. Home				Homemaker			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.				Balto.		Balto.		YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME (FIRST MIDDLE LAST)				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)		16. STREET ADDRESS			
Joseph Benz				Wezel		5508 Willys Ave. 21227			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No				213-74-2298		Mr. Reinhold Barchet - Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Rheumatic valvular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Rheumatic fever in childhood</u> PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>Atrial Fibrillation, Hot</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (GIVE NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
				P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE AT HOME <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION (CITY OR TOWN COUNTY STATE)	
22a. I certify that (1) this hospital attended the deceased from <u>9/12</u> 19 <u>85</u> to <u>10/27</u> 19 <u>85</u> that (1) (we) last saw the deceased alive on <u>10/24</u> 19 <u>85</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
<u>A. Alan Reisinger MD</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				10/30/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
A. Alan Reisinger MD				5411 Old Frederick Rd 21229					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN COUNTY STATE)	
Removal				10/27/85					
24. FUNERAL DIRECTOR (NAME)				ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Anatomy Board				Balto., Md.		NOV. 6. 1985		<u>Julia T. ...</u>	

COULDS

RECEIVED 10/10/55

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the doctor's certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 4 and 2 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JACKIE Jacqueline Virginia Barrett			2a. DATE OF DEATH MONTH DAY YEAR 10 26 85		2b. HOUR 11:50 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 3 1937		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS. # UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS. HOURS MIN.		
10. CITY OR TOWN OF DEATH Essex		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Residence (813-2B Brunswick Rd.)		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.		
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Essex		
14. FATHER'S NAME FIRST MIDDLE LAST James J. Sliwinski		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Imogene Horner		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 232-62-9542		17. INFORMANT ADDRESS Imogene H. Sliwinski 430 N. Dogwood Drive Harrisonburg, VA 22801		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PAST PROBABLY INTERNAL PERFORATION DUE TO, OR AS A CONSEQUENCE OF (b) DUODENAL CANCER DUE TO, OR AS A CONSEQUENCE OF (c) 2 1/2 years					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 HRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 3 19 85 , to 10/26 19 85 , that (I) (we) last saw the deceased alive on 10/9 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE G. Purcell		DEGREE M.D.		22c. DATE SIGNED 10/27/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL PURCELL		22e. ADDRESS 647.0012 Ad 2121				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 30, 1985		23c. NAME OF CEMETERY OR CREMATORY Presbyterian Cemetery		
24. FUNERAL DIRECTOR Charles M. Brown		23d. LOCATION CITY OR TOWN COUNTY STATE Gerrardstown Berkeley WV		25a. DATE REC'D. BY REGISTRAR NOV 1 1985		
Brown Funeral Home PO Box 821, Martinsburg, WV		25b. REGISTRAR'S SIGNATURE Julia Swanson				

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 1 5 0

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PHILIP BASS			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 22, 1985			2b. HOUR 11 A. M.				
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 30, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.				
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN ENCL. FRONT OF THIS ADDRESS) IN FRONT OF 5448 OLD CT. RD (21133)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY POLICE OFFICER		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTO. 13c. CITY OR TOWN RANDALLSTOWN 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE APT. 202 5448 OLD COURT RD. 21133										
14. FATHER'S NAME FIRST MIDDLE LAST BENJAMIN BASS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JENNIE ROSENBERG			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				
16b. SOCIAL SECURITY NO. 212-16-9248			17. INFORMANT ADDRESS MRS. MARGARET E. BASS 5448 OLD CT. RD., APT. 202 RANDALLSTOWN 21133							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Coronary</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>respiratory</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>respiratory</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>1949</u> , 19 <u>10-22-85</u> , to <u>10-22-85</u> , that (I) (we) last saw the deceased alive on <u>10-22-85</u> , 19 <u>10-22-85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE HARRY S. GIMBEL M.D.			DEGREE M.D.			22c. DATE SIGNED 10-23-85			22d. ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) HARRY S. GIMBEL			22f. ADDRESS 5326 BALTO. NAT. PIKE							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10/24/85		23c. NAME OF CEMETERY OR CREMATORY BNAI ISRAEL CEM		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. INC.						25a. DATE REC'D. BY REGISTRAR OCT 28 1985				
25b. REGISTRAR'S SIGNATURE Sol Levinson						26. ADDRESS 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215				

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be immediately filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

288073

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 1 5 1

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Henry Milford Bay			2a. DATE OF DEATH MONTH DAY YEAR October 4, 1985			2b. HOUR A M 10:30	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 24, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.	
10. CITY OR TOWN OF DEATH Lutherville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 101 Greenridge Road, 21093		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cabinet Maker		12b. KIND OF BUSINESS OR INDUSTRY Carpentry	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Lutherville		
14. FATHER'S NAME FIRST MIDDLE LAST Harry Clarkon Bay			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Peerce				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) ----- 212-01-7457		17. INFORMANT (Wife) ADDRESS #21093 Ethel M. Bay, 101 Greenridge Rd. Lutherville			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) ASPIRATION OF GASTRIC CONTENTS

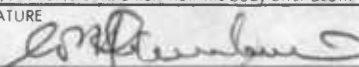
DUE TO, OR AS A CONSEQUENCE OF

(c) AND COPD.

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Constantinos Chilimindris, M.D.				22e. ADDRESS 6701 N. Charles St., 21204			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/7/85		23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Towson, Baltimore Co., Md.	
24. FUNERAL DIRECTOR NAME Martin D. Lawson				25a. DATE REC'D. BY REGISTRAR OCT 10 1985			
25b. REGISTRAR'S SIGNATURE Timonium							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it is to be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

25073

DATE: 10-1-58

TO: Mr. J. Edgar Hoover, Director, FBI

FROM: Mr. J. Edgar Hoover, Director, FBI

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

303111

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 1 5 2

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LOUIS JEROME BENZEL <i>LOUIS BENZEL</i>			2a. DATE OF DEATH MONTH DAY YEAR 10-26-85		2b. HOUR 6³⁵ PM						
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 27, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. COUNTY MD.					
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAINT JOSEPH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY C. & P. Telephone			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Carney		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9505 Fullerdale Ave. 21234			
14. FATHER'S NAME (TYPE OR PRINT) Charles MIDDLE Benzel LAST Benzel				15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) Margaret FIRST Margaret MIDDLE Albright LAST Albright							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. WW II 219-10-1801		17. INFORMANT ADDRESS L. Ruth Benzel - same as #13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) metastatic gastric adenocarcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>J.J. Kmetz MD</i>						DEGREE		22c. DATE SIGNED 10/26/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.J. KMETZ, MD						22e. ADDRESS Saint Joseph's Hospital - Osler Dr., 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-30-85		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville Balto. Md.				
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204						25a. DATE REC'D. BY REGISTRAR OCT 28 1985		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use on the burial/transit permit. Then please remove carbon paper 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.



308034

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 1 5 3

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DOROTHY MARIE ANNA BERBIG			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 29, 1985		2b. HOUR A M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR OCT. 3, 1919	6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY, MD.		
10. CITY OR TOWN OF DEATH 21234	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8532 WATER OAK ROAD 21234		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOSTESS	12b. KIND OF BUSINESS OR INDUSTRY RESTUARANT	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY BALTIMORE	13c. CITY OR TOWN 21234	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES J. HELLER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HEDWIG FRITZ		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) NO	16b. SOCIAL SECURITY NO. ----- 212-14-1484	17. INFORMANT ADDRESS PATRICIA E. HASLBECK 8632 OAK RD. 21234			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/15</u> , 19 <u>85</u> to <u>10/28</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>10/15</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.			
22b. SIGNATURE 		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 1205 YORK RD. 821-5707	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE NOV. 1, '85	23c. NAME OF CEMETERY OR CREMATORY DULANEY VALLEY MEM. GAR.	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CO., MD
24. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON		25a. DATE REC'D. BY REGISTRAR OCT 31 1985	25b. REGISTRAR'S SIGNATURE

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have the certificate signed by the funeral director and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, when any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 2 7 1 5 4
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

309078

1. DECEASED NAME (TYPE OR PRINT) Jack A. Bindon			2a. DATE OF DEATH MONTH 10 DAY 28 YEAR 85			2b. HOUR 12:20 AM								
3. SEX Male		4. RACE Cau.		5. DATE OF BIRTH MONTH 11 DAY 25 YEAR 25		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		7. UNDER 1 YEAR MONTHS 0 DAYS 0		8. UNDER 23 HRS. HOURS 0 MIN. 0				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ill.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Balto. County MD.					
10. CITY OR TOWN OF DEATH Balto.			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5633 North Ave.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor-Union Mem. Hosp.			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Balto.			13c. CITY OR TOWN Balto.			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 5633 North Ave. 21206		
14. FATHER'S NAME FIRST Roy MIDDLE B. LAST Bindon			15. MOTHER'S MAIDEN NAME FIRST Caroline MIDDLE Epling			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. W.W.II 365-22-9318			17. INFORMANT Corrine C. Bindon 5633 North Ave.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

cardio respiratory arrestAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**none**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

metastatic carcinoma of the esophagus**4 months**

DUE TO, OR AS A CONSEQUENCE OF

(c)

to pleura and pericardium**10 months**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

none

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Oct 24 19 85 to Oct 28 19 85 , that (I) (we) last saw the deceased alive on Oct 24 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.							
22b. SIGNATURE Victor R. Risch MD				DEGREE MD		22c. DATE SIGNED 10/25/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Victor R. Risch MD				22e. ADDRESS Johns Hopkins Oncology Center Baltimore MD 21205			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-30-85		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		23d. LOCATION CITY OR TOWN Balto. COUNTY Md. STATE Md.	
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24. FUNERAL DIRECTOR NAME John C. Miller Inc. 6415 Belair Rd.		ADDRESS NOV 01 1985		25a. DATE REC'D. BY REGISTRAR John C. Miller		25b. REGISTRAR'S SIGNATURE John C. Miller	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner, the medical examiner's assistant, or the medical examiner's assistant should be notified.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 1 5 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Francis Blackburn			2a. DATE OF DEATH MONTH DAY YEAR 10 31 85			2b. HOUR M AM					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 26 13		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 0 0		8. IF UNDER 24 HRS. HOURS MIN. 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Rosedale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1322 Rosewick Avenue 21237				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Produce		12b. KIND OF BUSINESS OR INDUSTRY Self-Employed			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Ulmont Blackburn				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Wesley							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-32-4675		17. INFORMANT ADDRESS Thelma Blackburn 1322 Rosewick Ave. 21237							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Parkinson's disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one day one day two years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR PM 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4/1/85 to 10/31/85 , that (I) (we) last saw the deceased alive on 4/1/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dennis W. MacDonald MD (276-1764)						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/1/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dennis W. MacDonald MD (276-1764)						22e. ADDRESS 9 S. Highland Ave. Balto., Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-4-1985		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home						24a. DATE REC'D. BY REGISTRAR NOV 05 1985		24b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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circumstances

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 1 5 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Eleanor Louise Blandford			2a. DATE OF DEATH MONTH DAY YEAR 10/21/85			2b. HOUR 6:12p M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 13 1907		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6701 N Charles St GBMC				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY -		
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Cockeysville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2 Stonegate Ct., 21030	
14. FATHER'S NAME FIRST MIDDLE LAST Herbert Rossmann			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie (Unknown)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 216-12-2995		17. INFORMANT ADDRESS William W. Blandford, Jr., 2 Stonegate Ct. 21030					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10/21 85 to 10/21 85 , that (I) (we) last saw the deceased alive on 10/21 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) shall not view the body after death.										
22b. SIGNATURE Jeffrey Foss M.D.			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/21/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. J. Foss			22e. ADDRESS GBMC							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 10/25/85		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. Md.			
24. FUNERAL DIRECTOR NAME Martin D. Lawson					25a. DATE REC'D. BY REGISTRAR OCT 23 1985		25b. REGISTRAR'S SIGNATURE <i>James S. Gonsky</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

February 1, 1917

Dear Sir:

I have the honor to acknowledge the receipt of your letter of January 31, 1917, in relation to the matter of the proposed amendment to the act of August 1, 1914, relating to the exportation of certain agricultural products.

The act of August 1, 1914, provides that the Secretary of Agriculture may, in his discretion, suspend the application of the provisions of the act in respect to any particular article or class of articles, or in respect to any particular country or class of countries, if he is satisfied that such suspension is in the public interest.

It is the policy of the Department to exercise this power in a liberal and judicious manner, and to take into consideration the interests of the producers and consumers of the articles in question, as well as the interests of the United States in the foreign market.

In the case of the proposed amendment to the act of August 1, 1914, relating to the exportation of certain agricultural products, the Department is of the opinion that the proposed amendment is not in the public interest, and therefore, it is not proposed to suspend the application of the provisions of the act in respect to the proposed amendment.

I am, Sir, very respectfully, yours, very truly, a servant of the United States.

Very truly yours,

John D. Hays, Secretary

Enclosed for you are two copies of the act of August 1, 1914, relating to the exportation of certain agricultural products, and a copy of the proposed amendment to the act.

I am, Sir, very respectfully, yours, very truly, a servant of the United States.

Very truly yours,

John D. Hays, Secretary

Enclosed for you are two copies of the act of August 1, 1914, relating to the exportation of certain agricultural products, and a copy of the proposed amendment to the act.

I am, Sir, very respectfully, yours, very truly, a servant of the United States.

Very truly yours,

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85

27157

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BETTY XX. BLANKMAN			2a. DATE OF DEATH MONTH DAY YEAR 10. 8. 85		2b. HOUR 2:45 P
3 SEX FEMALE	4 RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 9, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 76	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.		
10 CITY OR TOWN OF DEATH RANDALLSTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY AT HOEM	
13a. STATE MARYLAND	13b. COUNTY BALTO	13c. CITY OR TOWN BALTO	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST SOLOMON LURIE		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HANNAH UNKNOWN =			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 214-36-9848		17 INFORMANT ADDRESS MORTON BLANKMAN 7022 DEERFIELD RD. 21208	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I (this hospital) attended the deceased from 10/3 , 19 85 , to 10/8 , 19 85 , that (we) lost saw the deceased alive on 10/8 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Purnushottam Mitra		DEGREE		22c. DATE SIGNED 10. 8. 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PURNUSHOTTAM MITRA		22e. ADDRESS BALTIMORE COUNTY GENERAL HOSP.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 10/10/85	23c. NAME OF CEMETERY OR CREMATORY HEBREW YOUNG MENS CEM		23d. LOCATION CITY OR TOWN COUNTY BALTIMORE MARYLAND	
24 FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO, MD 21215		25a. DATE REC'D. BY REGISTRAR OCT 15 1985			
		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

741965

230179

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Christopher		2a. DATE OF DEATH October 1, 1985		2b. HOUR 1:50am M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH October 1, 1985		6. AGE (IN YEARS, LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN 10	
7a. BIRTHPLACE (STATE OR FOREIGN) U.S.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY None
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY Maryland Harford		13b. CITY OR TOWN Edgewood		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Burton Louis Blimline		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jeannine Louise Harris			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT 2411 Greenhart Lane 21040 Jeannine Louise Blimline-Mother	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Immaturity DUE TO, OR AS A CONSEQUENCE OF (b) Prevalable Infant 23 Weeks Gestation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from October 1, 1985, to October 1, 1985, that (we) lost saw the deceased alive on above, (we) (did) (did not) view the body after death.							
22b. SIGNATURE George Cavanagh, M.D.				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/1/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George Cavanagh, M.D.				22e. ADDRESS 9000 Franklin Square Drive Baltimore, MD. 21237			

23a. BURIAL, CREMATION, REMOVAL Disposal	23b. DATE 10/4/85	23c. NAME OF CEMETERY OR CREMATORY Franklin Square Hosp	23d. LOCATION 9000 Franklin Sq. Dr. 21237
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24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR OCT 16 1985	25b. REGISTRAR'S SIGNATURE Johnston
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send this certificate, pages 1 and 2, to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1 - STATE REGISTRAR		FOR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Myrtle M. BLUME								October 14, 1985		3:02p M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Female		White		May 6, 1896		89 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Washington DC		USA				Baltimore County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rossville		Franklin Square Hospital						Home Maker			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				Md.		Balto.		Towson		717 Seminary Ave. 21204	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Chandler				Amanda							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
no				212-74-7628		Mr. George E. Blume Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Nutritional Deficiency</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (X) (this hospital) attended the deceased from <u>October 13</u> , 19 <u>85</u> , to <u>October 14</u> , 19 <u>85</u> , that (X) (we) lost saw the deceased alive on <u>October 14</u> , 19 <u>85</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.											
22b. SIGNATURE <u>Maria Diaz, M.D.</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>10-14-85</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Maria Diaz, M.D.						22e. ADDRESS 9000 Franklin Square Drive Balto. 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		Oct. 17, 1985		Baltimore				Baltimore Md.			
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Leonard J. Ruck Inc. Baltimore, Maryland						OCT 15 1985		<u>J. Davidson</u>			

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THE UNIVERSITY OF CHICAGO

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Mr. George W. Blum, Jr.

October 1985

1990-1991

[illegible]

295057

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 271600

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Abram Katzenstein Blumenthal										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 19 85 OCT 15		2b. HOUR M 31					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 26, 1914		6. AGE (IN YEARS) LAST BIRTHDAY 70 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 19 85 OCT 15		2d. HOUR M 31					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County					
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6206 1/2 Haddon Avenue						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Importer				12b. KIND OF BUSINESS OR INDUSTRY Leather Goods			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland										13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6206 1/2 Haddon Avenue 21212	
14. FATHER'S NAME FIRST MIDDLE LAST Simon Blumenthal										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Birdye Katzenstein							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) World War II 213-05-5000		17. INFORMANT ADDRESS Elizabeth Blumenthal 6206 1/2 Haddon Avenue											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIO- VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (b) UASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE Paul F. Guerin				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER 1311 WESTERN RUN RD CUCKEYVILLE MD 21030				DATE SIGNED 10/17/85					
EXAMINER'S NAME (TYPE OR PRINT) PAUL F. GUERIN				ADDRESS 1311 WESTERN RUN RD CUCKEYVILLE MD 21030													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE October 17, 1985		23c. NAME OF CEMETERY OR CREMATORY Greenmount				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland							
24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home 6500 York Road - 21012										25a. DATE REC'D. BY REGISTRAR OCT 18 1985		25b. REGISTRAR'S SIGNATURE Lidia Davidson-Randall					

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BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 4 may be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mrs. Addie R. Bonner		2a. DATE OF DEATH MONTH DAY YEAR October 13 1985		2b. HOUR 11:30 A.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR November 15 1896	
6. AGE (IN YEARS LAST BIRTHDAY) 88		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County		10. CITY OR TOWN OF DEATH Pikesville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pikesville Nursing Home	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE 9213 Samoset Rd. 21133	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Randallstown	
14. FATHER'S NAME FIRST MIDDLE LAST James Alfred Gosnell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Ruth Brothers		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO. 220-48-1006		17. DECEASED'S ADDRESS Mr. James A. Bonner Sr. 9213 Samoset Rd. Randallstown Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF I APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: D. stroke					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 10/11/85 to 10/13/85 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (If we) (did) did not view the body after death.		22b. SIGNATURE Ellen	
22c. DATE SIGNED 10/14/85		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ellen		22e. ADDRESS Randallstown Md	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-16-85		23c. NAME OF CEMETERY OR CREMATORY Calvary Methodist Ch.	
23d. LOCATION CITY OR TOWN COUNTY STATE Gamber Carroll Maryland		24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc.		25a. DATE REC'D. BY REGISTRAR OCT 15 1985	
25b. REGISTRAR'S SIGNATURE Galia Davidson-Randall		25c. ADDRESS 8728 Liberty Road Randallstown, Maryland 21133		25d. SIGNATURE	

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Mr. Adair H. Bennett

October 11, 1960

Female

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November 12, 1960

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Female

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November 12, 1960

General

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85

27162

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDWARD JAMES BOYLE, SR.			2a. DATE OF DEATH MONTH DAY YEAR 10 15 85			2b. HOUR 10 50 AM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 6 18 1918		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN) COUNTY PA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH COUNTY TOWSON BALTIMORE MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RAIL ROAD		12b. KIND OF BUSINESS OR INDUSTRY	

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY BALTIMORE		13c. CITY OR TOWN COCKEYSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 26 Queensbride Court - 21030	
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD A BOYLE					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE CLARK					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 209102149		17. INFORMANT ADDRESS FAMILY RECORDS					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the Pancreas</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from 10-14, 19 85, to 10-15, 19 85, that X (we) last saw the deceased alive on 10-15, 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. X (we) (did) (did not) view the body after death.

22b. SIGNATURE <u>Beatriz P. Dizon, M.D.</u>		DEGREE M.D.		22c. DATE SIGNED 10/15/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BEATRIZ P. DIZON, M.D.		22e. ADDRESS 7620 YORK RD. TOWSON MD 21157			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 10-16-1985		23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
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24. FUNERAL DIRECTOR NAME EVANS CHARL OF CHIMES		ADDRESS 2325 YORK ROAD		25a. DATE REC'D. BY REGISTRAR OCT 22 1985		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James Bradigan			2a. DATE OF DEATH MONTH DAY YEAR 10 4 85			2b. HOUR M AM					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 10 11		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 0 0		8. IF UNDER 24 HRS. HOURS MIN. 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH County Balto., Md. MD.					
10. CITY OR TOWN OF DEATH Middle River		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 514 Wampler Rd. 21220				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Millwright		12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.			
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN 21220		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 514 Wampler Rd. 21220		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Bradigan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Ann Bowman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 214-18-5335		17. INFORMANT ADDRESS Lillian Bradigan 514 Wampler Rd. 21220							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Rectal Carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Altho ERROR RTZ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Cachexia											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE July 16 19 85 to October 4 19 85							
22a. I certify that (1) this hospital attended the deceased from July 8 19 85 and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (2) we (we) (did not) (did) not state the body after death.											
22b. SIGNATURE Paul Zechonsky, M.D.										22c. DATE SIGNED 10/4/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS 9000 Franklin Sq. Dr. Suite #205 #195	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-7-85		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County, Md.			
24. FUNERAL DIRECTOR Lessah Funeral Home											
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Oct 22 1985 John L. ...											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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• *Dealing with the Devil* by J. Edgar Hoover

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Salisbury County

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove golden tags from pages 1 and 2 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Austin Martin Brandenburg					2a. DATE OF DEATH MONTH DAY YEAR 10 13 1985					2b. HOUR 7 P. M.
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct 19 1897		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.				
10. CITY OR TOWN OF DEATH Woodlawn		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2315 Birch Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) mechanic		12b. KIND OF BUSINESS OR INDUSTRY auto		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Woodlawn		13e. STREET ADDRESS 2315 Birch Drive 21207				
14. FATHER'S NAME FIRST MIDDLE LAST Tracey Brandenburg					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Elizabeth Gaver					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-01-5189		17. INFORMANT ADDRESS 2315 Birch Drive Mary Brandenburg Woodlawn, MD 21207						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY ATHEROSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS ? YEARS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) NONE										
19a. DATE OF OPERATION 8-15-85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED DISSECTING ANEURYSM ABDOMINAL AORTA				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 10-19, 19 87, to 10-13, 19 85, that (I) (we) last saw the deceased alive on 10-11, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Leon Ashman		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10-17-85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEON ASHMAN				22e. ADDRESS 2510 TANEY RD. 21209						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-16-85		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion U. Methodist		23d. LOCATION CITY OR TOWN COUNTY STATE Myersville Frederick Maryland				
24. FUNERAL HOME Ricketts Funeral Home				ADDRESS Myersville, MD 21773		25a. DATE REC'D. BY REGISTRAR OCT 21 1985		25b. REGISTRAR'S SIGNATURE		

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Film 6609 item 16b

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1- FOR STATE REGISTRAR
11/14/85 rja

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WALTER BRANDT			2a. DATE OF DEATH MONTH DAY YEAR October 24, 1985			2b. HOUR 9 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR December 2, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Woodlawn		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5624 Johnnycake Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. Government		12b. KIND OF BUSINESS OR INDUSTRY Social Security Admin.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Woodlawn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5624 Johnnycake Road 21207	
14. FATHER'S NAME FIRST MIDDLE LAST George Brandt				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Ammer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO 212-07-2990 212-07-7556		17. INFORMANT ADDRESS Katherine A. Brandt Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Myelotic aneurysm resection & bypass surgery - left iliofemoral 1982</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5/27/77</u> , 19____, to <u>10/24/85</u> , 19____, that (I) (we) last saw the deceased alive on <u>Oct. 23</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Kennard Yaffee M.D.</u>				DEGREE <u>M.D.</u>				22c. DATE SIGNED <u>10/25/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kennard Yaffee M.D.				22e. ADDRESS 5501 Forest Park Avenue, Baltimore, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/26/85		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, MD. 21228						25a. DATE REC'D. BY REGISTRAR OCT 29 1985		25b. REGISTRAR'S SIGNATURE <u>John Burden Riddle</u>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed without delay after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SOL BRESSLER			2a. DATE OF DEATH MONTH DAY YEAR 10-28-85		2b. HOUR 6:52 PM
3. SEX MALE	4. RACE CAUC	5. DATE OF BIRTH MONTH DAY YEAR 6-6-06	6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALT COUNTY MD.		
10. CITY OR TOWN OF DEATH RANDALLSTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALT County Gen Hosp		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) SALESMAN	12b. KIND OF BUSINESS OR INDUSTRY RETAIL	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY BALT	13c. CITY OR TOWN BALT	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST ELI BRESSLER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MILLIE UNKNOWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-32-9960	17. INFORMANT HOWARD GOLDSMITH APT. 2C 6984 MILBROOK PARK DR. BALTO., MD 21215		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST 912 DUE TO, OR AS A CONSEQUENCE OF (b) ASPIRATION DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) NEPHROTIC SYNDROME CHRONIC ULCERATIVE COLITIS					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 10-9-1985 to 10-28-1985, that (I) (we) last saw the deceased alive on 10-28-1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE CHARLES SCHWARTZ MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-28-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES SCHWARTZ MD		22e. ADDRESS BALT County Gen Hosp RANDALLSTOWN MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCT. 30, 1985	23c. NAME OF CEMETERY OR CREMATORY HEBREW YOUNG MEN	23d. LOCATION CITY OR TOWN COUNTY BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215			25a. DATE REC'D. BY REGISTRAR OCT 31 1985		
			25b. REGISTRAR'S SIGNATURE		

302025



RESERVED FOR THE
20% CO. OWNERS



312014

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 1 6 1

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARY M. Brim			2a. DATE OF DEATH MONTH DAY YEAR 10 22 85			2b. HOUR 3:04 PM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2 23 04		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md. Baltimore County		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stella Maris Hospice				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic	
13a. STATE md.		13b. COUNTY BALTO.		13c. CITY OR TOWN Lutherville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST STEVEN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 219 56 9452		17. INFORMANT ADDRESS SUSAN BEALE 4496 51. GEORGE AVE.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **malignant mixed mesodermal mullerian tumor**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (he) (this hospital) attended the deceased from 10/21 , 19 85 , to 10/22 , 19 85 , that (he) (we) last saw the deceased alive on 10/22 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Kendall Faulkner MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-22-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kendall Faulkner				22e. ADDRESS Stella Maris Hospice			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/26/85		23c. NAME OF CEMETERY OR CREMATORY PLEASANT REST		23d. LOCATION CITY OR TOWN COUNTY STATE Towson BALTO md.	
24. FUNERAL DIRECTOR NAME ADDRESS CHATHAN HARRIS FN 1701 MCGIBB				25a. DATE REC'D. BY REGISTRAR NOV 1 1985		25b. REGISTRAR'S SIGNATURE John Davidson	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

1-10-16



291020

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 1 6 8

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST Virginia Marie Bucci			2a. DATE OF DEATH MONTH DAY YEAR October 11, 1985		2b. HOUR M AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 16, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIAGE STATUS MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.
10. CITY OR TOWN OF DEATH Eastpoint		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8008 Landsdale Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.			13b. COUNTY Balto.	13c. CITY OR TOWN Eastpoint	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 8008 Landsdale Rd. 21221
14. FATHER'S NAME FIRST MIDDLE LAST John Ketchum			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Libkey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 213-18-0607		17. INFORMANT ADDRESS Cecelia Citrano 419 Crisfield Rd. 21220		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) Debridement Mellitus APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes yes 1 yr.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7/9 1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I was was) attended the deceased from 8/30 19 85 , to 10/11 19 85 , that (I was was) last saw the deceased alive on 8/30 19 85 , and that in (my own own) opinion death occurred on the date and hour and from the causes stated above. (I was was) (did not) view the body after death.						
22b. SIGNATURE Louis E. O'Sullivan				22c. DATE SIGNED 10/12/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louis E. O'Sullivan				22e. ADDRESS 1012 OLD N.B.T. Rd. BALTIMORE 21224		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/14/85		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus		
23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk Baltimore Md.		24. FUNERAL DIRECTOR NAME ADDRESS Connelly Funeral Home 300 Mace Ave. 21221		25a. DATE REC'D. BY REGISTRAR OCT 16 1985		
25b. REGISTRAR'S SIGNATURE Cecelia Citrano						

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

231030



20% COTTON FIBER

WILSON & WILSON

311132

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 1 6 9

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bernard J. Buczkowski			2a. DATE OF DEATH MONTH DAY YEAR 10 25 85			2b. HOUR M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 9 1922		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Carney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3034 Third Avenue 21234				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY Heilemann	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3034 Third Ave. Balto., Md. 21234	
14. FATHER'S NAME FIRST MIDDLE LAST Victor Buczkowski				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Winiecki					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW1 213-14-8815		17. INFORMANT ADDRESS Rita L. Buczkowski 3034 Third Ave. 21234					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic adenocarcinoma of colon DUE TO, OR AS A CONSEQUENCE OF (b) Divus chondroma - brain tumor DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dana Frank, M. D.				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10/28/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dana Frank, M. D. (528-1523)				22e. ADDRESS 611 Park Avenue Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-28-85		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home				ADDRESS 4401 Belair Rd. BALTO. MD. 21236		25a. DATE REC'D. BY REGISTRAR 11/30/85		25b. REGISTRAR'S SIGNATURE	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This permit is to be used for the removal of the body to the place of interment. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, a medical examiner must be notified at once.

311132

1952	1951	1950	1949	1948	1947	1946	1945	1944	1943	1942	1941	1940	1939	1938	1937	1936	1935	1934	1933	1932	1931	1930	1929	1928	1927	1926	1925	1924	1923	1922	1921	1920	1919	1918	1917	1916	1915	1914	1913	1912	1911	1910	1909	1908	1907	1906	1905	1904	1903	1902	1901	1900	1899	1898	1897	1896	1895	1894	1893	1892	1891	1890	1889	1888	1887	1886	1885	1884	1883	1882	1881	1880	1879	1878	1877	1876	1875	1874	1873	1872	1871	1870	1869	1868	1867	1866	1865	1864	1863	1862	1861	1860	1859	1858	1857	1856	1855	1854	1853	1852	1851	1850	1849	1848	1847	1846	1845	1844	1843	1842	1841	1840	1839	1838	1837	1836	1835	1834	1833	1832	1831	1830	1829	1828	1827	1826	1825	1824	1823	1822	1821	1820	1819	1818	1817	1816	1815	1814	1813	1812	1811	1810	1809	1808	1807	1806	1805	1804	1803	1802	1801	1800	1799	1798	1797	1796	1795	1794	1793	1792	1791	1790	1789	1788	1787	1786	1785	1784	1783	1782	1781	1780	1779	1778	1777	1776	1775	1774	1773	1772	1771	1770	1769	1768	1767	1766	1765	1764	1763	1762	1761	1760	1759	1758	1757	1756	1755	1754	1753	1752	1751	1750	1749	1748	1747	1746	1745	1744	1743	1742	1741	1740	1739	1738	1737	1736	1735	1734	1733	1732	1731	1730	1729	1728	1727	1726	1725	1724	1723	1722	1721	1720	1719	1718	1717	1716	1715	1714	1713	1712	1711	1710	1709	1708	1707	1706	1705	1704	1703	1702	1701	1700	1699	1698	1697	1696	1695	1694	1693	1692	1691	1690	1689	1688	1687	1686	1685	1684	1683	1682	1681	1680	1679	1678	1677	1676	1675	1674	1673	1672	1671	1670	1669	1668	1667	1666	1665	1664	1663	1662	1661	1660	1659	1658	1657	1656	1655	1654	1653	1652	1651	1650	1649	1648	1647	1646	1645	1644	1643	1642	1641	1640	1639	1638	1637	1636	1635	1634	1633	1632	1631	1630	1629	1628	1627	1626	1625	1624	1623	1622	1621	1620	1619	1618	1617	1616	1615	1614	1613	1612	1611	1610	1609	1608	1607	1606	1605	1604	1603	1602	1601	1600	1599	1598	1597	1596	1595	1594	1593	1592	1591	1590	1589	1588	1587	1586	1585	1584	1583	1582	1581	1580	1579	1578	1577	1576	1575	1574	1573	1572	1571	1570	1569	1568	1567	1566	1565	1564	1563	1562	1561	1560	1559	1558	1557	1556	1555	1554	1553	1552	1551	1550	1549	1548	1547	1546	1545	1544	1543	1542	1541	1540	1539	1538	1537	1536	1535	1534	1533	1532	1531	1530	1529	1528	1527	1526	1525	1524	1523	1522	1521	1520	1519	1518	1517	1516	1515	1514	1513	1512	1511	1510	1509	1508	1507	1506	1505	1504	1503	1502	1501	1500	1499	1498	1497	1496	1495	1494	1493	1492	1491	1490	1489	1488	1487	1486	1485	1484	1483	1482	1481	1480	1479	1478	1477	1476	1475	1474	1473	1472	1471	1470	1469	1468	1467	1466	1465	1464	1463	1462	1461	1460	1459	1458	1457	1456	1455	1454	1453	1452	1451	1450	1449	1448	1447	1446	1445	1444	1443	1442	1441	1440	1439	1438	1437	1436	1435	1434	1433	1432	1431	1430	1429	1428	1427	1426	1425	1424	1423	1422	1421	1420	1419	1418	1417	1416	1415	1414	1413	1412	1411	1410	1409	1408	1407	1406	1405	1404	1403	1402	1401	1400	1399	1398	1397	1396	1395	1394	1393	1392	1391	1390	1389	1388	1387	1386	1385	1384	1383	1382	1381	1380	1379	1378	1377	1376	1375	1374	1373	1372	1371	1370	1369	1368	1367	1366	1365	1364	1363	1362	1361	1360	1359	1358	1357	1356	1355	1354	1353	1352	1351	1350	1349	1348	1347	1346	1345	1344	1343	1342	1341	1340	1339	1338	1337	1336	1335	1334	1333	1332	1331	1330	1329	1328	1327	1326	1325	1324	1323	1322	1321	1320	1319	1318	1317	1316	1315	1314	1313	1312	1311	1310	1309	1308	1307	1306	1305	1304	1303	1302	1301	1300	1299	1298	1297	1296	1295	1294	1293	1292	1291	1290	1289	1288	1287	1286	1285	1284	1283	1282	1281	1280	1279	1278	1277	1276	1275	1274	1273	1272	1271	1270	1269	1268	1267	1266	1265	1264	1263	1262	1261	1260	1259	1258	1257	1256	1255	1254	1253	1252	1251	1250	1249	1248	1247	1246	1245	1244	1243	1242	1241	1240	1239	1238	1237	1236	1235	1234	1233	1232	1231	1230	1229	1228	1227	1226	1225	1224	1223	1222	1221	1220	1219	1218	1217	1216	1215	1214	1213	1212	1211	1210	1209	1208	1207	1206	1205	1204	1203	1202	1201	1200	1199	1198	1197	1196	1195	1194	1193	1192	1191	1190	1189	1188	1187	1186	1185	1184	1183	1182	1181	1180	1179	1178	1177	1176	1175	1174	1173	1172	1171	1170	1169	1168	1167	1166	1165	1164	1163	1162	1161	1160	1159	1158	1157	1156	1155	1154	1153	1152	1151	1150	1149	1148	1147	1146	1145	1144	1143	1142	1141	1140	1139	1138	1137	1136	1135	1134	1133	1132	1131	1130	1129	1128	1127	1126	1125	1124	1123	1122	1121	1120	1119	1118	1117	1116	1115	1114	1113	1112	1111	1110	1109	1108	1107	1106	1105	1104	1103	1102	1101	1100	1099	1098	1097	1096	1095	1094	1093	1092	1091	1090	1089	1088	1087	1086	1085	1084	1083	1082	1081	1080	1079	1078	1077	1076	1075	1074	1073	1072	1071	1070	1069	1068	1067	1066	1065	1064	1063	1062	1061	1060	1059	1058	1057	1056	1055	1054	1053	1052	1051	1050	1049	1048	1047	1046	1045	1044	1043	1042	1041	1040	1039	1038	1037	1036	1035	1034	1033	1032	1031	1030	1029	1028	1027	1026	1025	1024	1023	1022	1021	1020	1019	1018	1017	1016	1015	1014	1013	1012	1011	1010	1009	1008	1007	1006	1005	1004	1003	1002	1001	1000	999	998	997	996	995	994	993	992	991	990	989	988	987	986	985	984	983	982	981	980	979	978	977	976	975	974	973	972	971	970	969	968	967	966	965	964	963	962	961	960	959	958	957	956	955	954	953	952	951	950	949	948	947	946	945	944	943	942	941	940	939	938	937	936	935	934	933	932	931	930	929	928	927	926	925	924	923	922	921	920	919	918	917	916	915	914	913	912	911	910	909	908	907	906	905	904	903	902	901	900	899	898	897	896	895	894	893	892	891	890	889	888	887	886	885	884	883	882	881	880	879	878	877	876	875	874	873	872	871	870	869	868	867	866	865	864	863	862	861	860	859	858	857	856	855	854	853	852	851	850	849	848	847	846	845	844	843	842	841	840	839	838	837	836	835	834	833	832	831	830	829	828	827	826	825	824	823	822	821	820	819	818	817	816	815	814	813	812	811	810	809	808	807	806	805	804	803	802	801	800	799	798	797	796	795	794	793	792	791	790	789	788	787	786	785	784	783	782	781	780	779	778	777	776	775	774	773	772	771	770	769	768	767	766	765	764	763	762	761	760	759	758	757	756	755	754	753	752	751	750	749	748	747	746	745	744	743	742	741	740	739	738	737	736	735	734	733	732	731	730	729	728	727	726	725	724	723	722	721	720	719	718	717	716	715	714	713	712	711	710	709	708	707	706	705	704	703	702	701	700	699	698	697	696	695	694	693	692	691	690	689	688	687	686	685	684	683	682	681	680	679	678	677	676	675	674	673	672	671	670	669	668	667	666	665	664	663	662	661	660	659	658	657	656	655	654	653	652	651	650	649	648	647	646	645	644	643	642	641	640	639	638	637	636	635	634	633	632	631	630	629	628	627	626	625	624	623	622	621	620	619	618	617	616	615	614	613	612	611	610	609	608	607	606	605	604	603	602	601	600	599	598	597	596	595	594	593	592	591	590	589	588	587	586	585	584	583	582	581	580	579	578	577	576	575	574	573	572	571	570	569	568	567	566	565	564	563	562	561	560	559	558	557	556	555	554	553	552	551	550	549	548	547	546	545	544	543	542	541	540	539	538	537	536	535	534	533	5
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303041

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 1 7 0

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MEYER			2a. DATE OF DEATH MONTH DAY YEAR 10-19-85			2b. HOUR 8:15 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR JULY 22, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Proprietor		12b. KIND OF BUSINESS OR INDUSTRY Grocery	
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Herschel Budlow			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leah Unknown			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
16b. SOCIAL SECURITY NO. 216-32-6959			17. INFORMANT ADDRESS Mrs. Ida Budlow 7906 Milbury Road 21207						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA - STAPHYLOCOCCUS Aureus DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) DIABETIS mellitus; RENAL Failure									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 10-11 , 19 85 , to 10-19 , 19 85 , that (I) (we) last saw the deceased alive on 10-19 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE 			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-19-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ORLANDO B. CONWAY, M.D.			22e. ADDRESS BCEH - RANDALLSTOWN AID. 21133						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE October 20/85		23c. NAME OF CEMETERY OR CREMATORY Hebrew Young Mens		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		
24. FUNERAL DIRECTOR NAME sol levinson & Bros. Inc.			ADDRESS 6010 REISTERSTOWN RD.			25a. DATE REC'D. BY REGISTRAR OCT 28 1985		25b. REGISTRAR'S SIGNATURE 	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it may be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 is signed, any injury, or other traumatic event, the medical examiner must be notified at once.

140808



287075

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 1 7 1

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) MARTIN			2a. DATE OF DEATH MONTH DAY YEAR 10 8 85			2b. HOUR 12.05 PM			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 2 2 1898		6 AGE (IN YEARS (LAST BIRTHDAY)) 87		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, Md.			
10 CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Miner		12b. KIND OF BUSINESS OR INDUSTRY Coal	
13a. STATE Pennsylvania			13b. COUNTY Lackawanna		13c. CITY OR TOWN Scranton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Martin			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Angela M. Marangi			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 196-03-2812			17 INFORMANT ADDRESS Scranton, Pa. Sarah Bufano 1628 South Webster Ave.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY CARDIAC ASYSTOLE DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) COAL MINERS LUNG									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: POSSIBLE CA. OF LUNG. ATRIAL FIBRILLATION P.V.C's									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Hafeez A Syed					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/8/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAFEEZ A SYED					22e. ADDRESS BALTIMORE COUNTY GEN. HOSP.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-12-85		23c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Scranton, Lackawanna, Pa.		
24. FUNERAL DIRECTOR Marzullo Funeral Service ADDRESS Reisterstown, Md					25a. DATE REC'D. BY REGISTRAR OCT 9 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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295043

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the deceased has been pronounced dead, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the permit. Page 4 should be filed with the permit. Page 5 should be filed with the permit. Page 6 should be filed with the permit. Page 7 should be filed with the permit. Page 8 should be filed with the permit. Page 9 should be filed with the permit. Page 10 should be filed with the permit. Page 11 should be filed with the permit. Page 12 should be filed with the permit. Page 13 should be filed with the permit. Page 14 should be filed with the permit. Page 15 should be filed with the permit. Page 16 should be filed with the permit. Page 17 should be filed with the permit. Page 18 should be filed with the permit. Page 19 should be filed with the permit. Page 20 should be filed with the permit. Page 21 should be filed with the permit. Page 22 should be filed with the permit. Page 23 should be filed with the permit. Page 24 should be filed with the permit. Page 25 should be filed with the permit. Page 26 should be filed with the permit. Page 27 should be filed with the permit. Page 28 should be filed with the permit. Page 29 should be filed with the permit. Page 30 should be filed with the permit. Page 31 should be filed with the permit. Page 32 should be filed with the permit. Page 33 should be filed with the permit. Page 34 should be filed with the permit. Page 35 should be filed with the permit. Page 36 should be filed with the permit. Page 37 should be filed with the permit. Page 38 should be filed with the permit. Page 39 should be filed with the permit. Page 40 should be filed with the permit. Page 41 should be filed with the permit. Page 42 should be filed with the permit. Page 43 should be filed with the permit. Page 44 should be filed with the permit. Page 45 should be filed with the permit. Page 46 should be filed with the permit. Page 47 should be filed with the permit. Page 48 should be filed with the permit. Page 49 should be filed with the permit. Page 50 should be filed with the permit. Page 51 should be filed with the permit. Page 52 should be filed with the permit. Page 53 should be filed with the permit. Page 54 should be filed with the permit. Page 55 should be filed with the permit. Page 56 should be filed with the permit. Page 57 should be filed with the permit. Page 58 should be filed with the permit. Page 59 should be filed with the permit. Page 60 should be filed with the permit. Page 61 should be filed with the permit. Page 62 should be filed with the permit. Page 63 should be filed with the permit. Page 64 should be filed with the permit. Page 65 should be filed with the permit. Page 66 should be filed with the permit. Page 67 should be filed with the permit. Page 68 should be filed with the permit. Page 69 should be filed with the permit. Page 70 should be filed with the permit. Page 71 should be filed with the permit. Page 72 should be filed with the permit. Page 73 should be filed with the permit. Page 74 should be filed with the permit. Page 75 should be filed with the permit. Page 76 should be filed with the permit. Page 77 should be filed with the permit. Page 78 should be filed with the permit. Page 79 should be filed with the permit. Page 80 should be filed with the permit. Page 81 should be filed with the permit. Page 82 should be filed with the permit. Page 83 should be filed with the permit. Page 84 should be filed with the permit. Page 85 should be filed with the permit. Page 86 should be filed with the permit. Page 87 should be filed with the permit. Page 88 should be filed with the permit. Page 89 should be filed with the permit. Page 90 should be filed with the permit. Page 91 should be filed with the permit. Page 92 should be filed with the permit. Page 93 should be filed with the permit. Page 94 should be filed with the permit. Page 95 should be filed with the permit. Page 96 should be filed with the permit. Page 97 should be filed with the permit. Page 98 should be filed with the permit. Page 99 should be filed with the permit. Page 100 should be filed with the permit.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 1 7 2

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST LAST MIDDLE Devraux W. Bull			2a. DATE OF DEATH MONTH DAY YEAR October 13, 1985			2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 15, 1939		6. AGE (IN YEARS (LAST BIRTHDAY)) 46 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1915 Jasmine Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dependent	
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk	
14. FATHER'S NAME FIRST MIDDLE LAST Winfred James Bull		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Mae Outten					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-34-1238		17. INFORMANT ADDRESS Bernard Mayo 312 3rd Ave. Balto. 21227			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC MELANOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>~6 MONTHS</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>HEPATIC FAILURE</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (1) (this hospital) attended the deceased from <u>OCT 8, 1985</u> to <u>OCT 12, 1985</u> , that (1) (we) last saw the deceased alive on <u>OCT 12, 1985</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>DS Raiford</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-14-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David Raiford, M.D.				22e. ADDRESS The Johns Hopkins Hospital Balto. Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 16, 1985		23c. NAME OF CEMETERY OR CREMATORY Glen Haven		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Duda-Ruck Funeral Home of Dundalk, Inc.				25a. DATE REC'D. BY REGISTRAR OCT 18 1985		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	



301067

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VIR A15 ME (5))
15M 7/76

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WALTER T. BURKE						2b. DATE KNOWN OF DEATH ESTIMATED Oct 21 1985		2d. HOUR 1:30 PM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 29, 1917	6. AGE (IN YEARS) LAST BIRTHDAY 67 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD October 21 1985		2d. HOUR 7 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD			
10. CITY OR TOWN OF DEATH Sparks		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 15823 Yeoho Rd., 21152				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Automotive - General Motors		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. CITY Baltimore		13c. CITY OR TOWN Sparks		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 15823 Yeoho Rd, 21152	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Burke				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gussie V. Sayer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 228-14-8378		17. INFORMANT Mr. Tommy D. Burke, Sparks, Md. 21152					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden M.I. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) ASCD with Coronary Insuff 2 1/2% DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE Charles F. O'Donnell		TITLE (SPECIFY) Deputy						MEDICAL EXAMINER DATE SIGNED 10/2/85	
EXAMINER'S NAME (TYPE OR PRINT) Charles F. O'Donnell, MD		ADDRESS York Rd., Towson, Md. 21204							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-25-85		23c. NAME OF CEMETERY OR CREMATORY Russell Mem. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Lebanon, Russell Co. Virginia			
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.				ADDRESS Towson, Md. 21204		25a. DATE REC'D. BY REGISTRAR OCT 24 1985		25b. REGISTRAR'S SIGNATURE	

301067



301067

283101

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85

27174

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Dewey		FIRST W.		MIDDLE Burner		LAST		2a. DATE OF DEATH MONTH DAY YEAR October 3, 1985		2b. HOUR 8:40 p.m.	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 9 12 1898		6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10 CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cafeteria Worker		12b. KIND OF BUSINESS OR INDUSTRY ARA Services			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 63 Self Ridge Rd. 21220	
14 FATHER'S NAME FIRST MIDDLE LAST Ubanus				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah J. Burner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1/20- 1/12		17 INFORMANT Bonnie French		ADDRESS 8821 Trimble Way 21237			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) _____			
DUE TO, OR AS A CONSEQUENCE OF (c) _____			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from September 12, 19 85 , to October 3, 19 85 , that (we) last saw the deceased alive on October 3, 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.			
22b. SIGNATURE A. Pidloan		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED 10-			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. Pidloan, M.D.		22e. ADDRESS 9000 Franklin Square Drive, 21237	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/5/85		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24 FUNERAL DIRECTOR NAME ADDRESS Duda-Ruck Inc. 7922 Wise Ave. Baltimore, Maryland 21222				25a. DATE REC'D. BY REGISTRAR OCT 8 1985		25b. REGISTRAR'S SIGNATURE J. L. Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.



304089

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 1 7 5

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELizabeth			LAST (Burns) BURNES			2a. DATE OF DEATH MONTH DAY YEAR 10-25-85			2b. HOUR 10⁴⁰ A.M.		
3. SEX Female			4. RACE black			5. DATE OF BIRTH MONTH DAY YEAR 4 9 02			6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pikesville Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Robert Taylor			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma NA			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-077145		
17. INFORMANT ADDRESS Mary Robinson 2321 Anoka Avenue			17. INFORMANT ADDRESS 2321 Anoka Avenue			17. INFORMANT ADDRESS 2321 Anoka Avenue			17. INFORMANT ADDRESS 2321 Anoka Avenue		
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED DURING <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (i) (this hospital) attended the deceased from 10-9-85 19 85 to 10-25 19 85 that (i) (we) last saw the deceased alive on 10-9 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Harold B. Bobbitt DEGREE										22c. DATE SIGNED 10-27-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD B. BOBBITT										22e. ADDRESS 7720 Park Heights 21208	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/31/85			23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park			23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus MD		
24. FUNERAL DIRECTOR NAME ADDRESS William C. March F/H Inc West 4300 Wabash Ave										25a. DATE REC'D. BY REGISTRAR OCT 29 1985	
25b. REGISTRAR'S SIGNATURE [Signature]											

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, then official investigation is required at death.

BP

297134

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 27 176

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LOUIS F BUSCEMI			2a. DATE OF DEATH MONTH DAY YEAR OCT. 21, 1985		2b. HOUR 5:48AM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR DEC. 13 1920	6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.		
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER BALTIMORE MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN	12b. KIND OF BUSINESS OR INDUSTRY B. RCH CO.	
13a. STATE MD.			13b. CITY OR TOWN BALTIMORE	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 4308 EDRO AVENUE 21236
14. FATHER'S NAME FIRST MIDDLE LAST CARMELA BUSCEMI			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY BUCHERRI		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 220-09-0437	17. INFORMANT ADDRESS LILLIAN BUSCEMI (WIFE) SAME ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) HYPOTENSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) CARDIAC TAMPONADE PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) LUNG CANCER					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from OCT. 19 19 85 , to OCT. 21 19 85 , that (I) <u>was</u> last saw the deceased alive on OCT. 21 19 85 , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above (I <u>was</u> / <u>we</u> / <u>did not</u> view the body after death)					
22b. SIGNATURE <i>David G. Roberts</i>			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID G. ROBERTS, M.D.			22e. ADDRESS GREATER BALTIMORE MEDICAL CENTER		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 10/24/85	23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE	MD.	
24. FUNERAL DIRECTOR SCHIMONEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213			25a. DATE REC'D. BY REGISTRAR OCT 22 1985	25b. REGISTRAR'S SIGNATURE <i>Julia Anderson-Hendell</i>	

MEDICAL CERTIFICATION

99

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be immediately filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

REVISED

30% COTTON FIBER

CHIEF MINT



297037

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 1 7 7

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FRANK A. BYERS			2a. DATE OF DEATH MONTH 10 DAY 12 YEAR 85		2b. HOUR 0845 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH Feb DAY 18 YEAR 1898		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. MONTHS 7 DAYS 24 HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co., MD.	
10. CITY OR TOWN OF DEATH Randallstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balto. County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer-Retired		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland	13b. COUNTY Carroll	13c. CITY OR TOWN Mt. Airy	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5701 Ridge Rd. 21771	
14. FATHER'S NAME FIRST Thomas MIDDLE Byers LAST Byers		15. MOTHER'S MAIDEN NAME FIRST Rosie MIDDLE Franklin LAST Franklin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-36-3988		17. INFORMANT ADDRESS Westminster, Md. Sandra L. Hutsell, 135 City View Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis Dehydration DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10-11-19-85 to 10-12-19-85 , that (I) (we) lost saw the deceased alive on 10-12-19-85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Rayado RG G. QAO		DEGREE MD		22c. DATE SIGNED 10-12-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAYADO RG G. QAO		22e. ADDRESS BALTO COUNTY GNC HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10-15-1985	23c. NAME OF CEMETERY Taylorsville		23d. LOCATION CITY OR TOWN COUNTY STATE Taylorsville, Carroll, Md.	
24. FUNERAL DIRECTOR NAME Charles W. Burrier, Jr., Sykesville, Md.		25a. DATE REC'D. BY REGISTRAR OCT 18 1985		25b. REGISTRAR'S SIGNATURE Julia Taylor-Rodriguez	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be furnished for use as the burial permit. Then please remove this certificate. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

BP

288092

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 1 7 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Matilda CAIRNS			2a. DATE OF DEATH MONTH DAY YEAR October 9, 1985			2b. HOUR 1:30 PM			
1. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4-5-1904		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor-Eastern Ventian		12b. KIND OF BUSINESS OR INDUSTRY Blind		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3119 Kentucky Ave., 21213	
14. FATHER'S NAME FIRST MIDDLE LAST Otto Thomas				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Gerhold					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-20-9187		17. INFORMANT ADDRESS Lillian M. Kerner, 5634 Whitby					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Pseudomonas pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 29 , to October 9, 1985 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 9, 1985 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.									
22b. SIGNATURE L. Villalobos, M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. Villalobos					22e. ADDRESS 9000 Franklin Square Drive, 21237				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-12-85		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Balto., MD		
24. FUNERAL DIRECTOR NAME John C. Miller, Inc., 6415 Belair Rd. 21206					25a. DATE REC'D. BY REGISTRAR OCT 10 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked on item 18 shows only injury, or other traumatic event, the medical examiner must be notified at once.



281076

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARIE L CALTRIDER			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 19 85 10			2b. HOUR 19 85 10		
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 1 30 1911	6. AGE (IN YEARS) (LAST BIRTHDAY) 74 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD OCT 1 19 85		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County		
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Medical Secretary		12b. KIND OF BUSINESS OR INDUSTRY Johns Hopkins
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 2616 Wycliffe Rd. 21234								
14. FATHER'S NAME FIRST MIDDLE LAST George Langville				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Della				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-12-8423		17. INFORMANT Bernard Caltrider				
				ADDRESS 21234 Wycliffe Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC AND DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE CARDIOVASCULAR DUE TO, OR AS A CONSEQUENCE OF (c) DISEASE								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the body described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Paul F Guerin		TITLE (SPECIFY) DEPUTY		M.D.		DATE SIGNED OCT 1, 1985		
EXAMINER'S NAME (TYPE OR PRINT) PAUL F GUERIN		ADDRESS 1311 WESTERN RUN RD COCKEYSVILLE MD 21030						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-4-85		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley M. G.			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Lassaby Funeral Home		ADDRESS 7401 Belmar Rd. BARTO, MD. 21236		25a. DATE REC'D. BY REGISTRAR OCT 04 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

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Oct 8

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Baltimore County

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1917

Medical Secretary, Johns Hopkins

St. Joseph Hospital

Perthville

xx John Speilberg, Esq.

Baltimore

John

Perthville

George

1917

Bernard Calender sold Speilberg

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1917-1918

RECEIVED

1917

Baltimore, Maryland

Baltimore, Maryland

1917-1918

1917

290022

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Joseph William Cameron			2a. DATE OF DEATH MONTH DAY YEAR October 13, 1985		2b. HOUR 5:30AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 4 21 1898		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Rossville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman	12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Dundalk	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2900 Cornwall Rd. 21222	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Elbert Cameron		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sallie J. Cheek			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 213/09/3508		17. INFORMANT ADDRESS Mildred C. Cameron (wife) (same as 13e.)	

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.(b) Respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF

(c) Possible gastrointestinal bleedAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from <u>October 2, 1985</u> to <u>October 13, 1985</u> , that (we) last saw the deceased alive on <u>October 13, 1985</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Sara Breitman MD</u>	DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <u>10/13/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Sara Breitman MD</u>	22e. ADDRESS <u>9000 Franklin Square Drive 21237</u>		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/16/1985	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Rosedale Balto., Md.
24. FUNERAL DIRECTOR NAME ADDRESS Walter Brooks Bradley Inc. Balto., Md. 21222		25a. REC'D. BY REGISTRAR <u>06/15/1985</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

350923

297149

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ethel R. Campbell			2a. DATE OF DEATH MONTH DAY YEAR 10/15/85			2b. HOUR 7:15p M					
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCT-2, 1908		6 AGE (IN YEARS LAST BIRTHDAY) 77		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U-S-A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10 CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6701 N Charles St GBMC				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AT Home		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY Baltimore		13c. CITY OR TOWN PARKVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2935 HISS AVE. 21234		
14 FATHER'S NAME FIRST MIDDLE LAST JAMES LAMPKIN			15 MOTHER'S NAME FIRST MIDDLE LAST MARGARET LAMPKIN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214 342910		17 INFORMANT ADDRESS FAMILY RECORDS						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									(b) Cerebral Hemorrhage Months		
DUE TO, OR AS A CONSEQUENCE OF									(c) DUE TO, OR AS A CONSEQUENCE OF		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10. Chronic Obstructive Lung Disease/Congestive Heart Failure											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10/15 1985 to 10/15 1985 that (I) (we) last saw the deceased alive on 10/15 1985 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Jeanne J. Wernicki						DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/15/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. J Wernicki						22e. ADDRESS GBMC					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10-19-1985		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. PK.			23d. LOCATION CITY OR TOWN COUNTY STATE PARKVILLE BALTO MARYLAND			
24 FUNERAL DIRECTOR NAME EVANS CHAPEL OF MEMORIES HARFORD						24b. ADDRESS 8800 ROAD		25a. DATE REC'D. BY REGISTRAR OCT 22 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be detached for use as the burial-transit permit. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

100

2

309088

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 1 8 2

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANTOINETTE E. CAMPION			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 28, 1985		2b. HOUR 11:40^{PM}
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 12, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE COUNTY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FREDERICK VILLA NURSING CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME MAKER	12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. STATE MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN CATONSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 136 EDGEWOOD AVE BALTO. 21228	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN STOCK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANTOINETTE HESSLER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-03-3703	17. INFORMANT ADDRESS JOHN J. CAMPION 136 EDGEWOOD AVENUE 21228			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

Cardiorespiratory Arrest
Alzheimer's Disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH*minutes**years*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) was (did not) attend the deceased from <u>10/13</u> , 19 <u>85</u> , to <u>10/28</u> , 19 <u>85</u> , that (I) was (lost) saw the deceased alive on <u>10/13</u> , 19 <u>85</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did not) view the body after death.			
22b. SIGNATURE <i>James McLean</i>	DEGREE <i>MD</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>10/29/85</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>NOELAN</i>		22e. ADDRESS <i>1 Mallory Hill Rd Balt Md 21229</i>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/31/85	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke		25. DATE REC'D. BY REGISTRAR NOV 01 1985 REGISTRAR'S SIGNATURE <i>[Signature]</i>	
1630 Edmondson Avenue Baltimore Maryland 21228			

22000

309044

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) CLARA M CARMINE			2a. DATE OF DEATH MONTH DAY YEAR 10 24 85		2b. HOUR 6⁵⁰ A M	
3 SEX FEMALE		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 1 1893		
6 AGE (IN YEARS LAST BIRTHDAY) 91		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH County MD		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12b. KIND OF BUSINESS OR INDUSTRY Hospital		
10. CITY OR TOWN OF DEATH County-Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN Phoenix		
14. FATHER'S NAME FIRST MIDDLE LAST LOUIS E. MILLER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TALIBERT				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-22-5598		17. INFORMANT ADDRESS FAMILY RECORDS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pneumonia & Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 10-21-1985 to 10-24-1985 , that (I) (we) last saw the deceased alive on 10-24-1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE A. H. Ghiladi				22c. DATE SIGNED 10-24-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. H. GHILADI, MD				22e. ADDRESS 7600 OSLER Dr. Towson		
23a. BURIAL CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCT. 26, 1985		23c. NAME OF CEMETERY OR CREMATORY POPLAR GROVE CEM.		
24. FUNERAL DIRECTOR EVANS CHAPEL OF CHIMES		25a. DATE REC'D. BY REGISTRAR NOV 01 1985		25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION

29

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified by the hospital or attending physician.

BP

110095

290070

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) RUTH M. CARROLL			2a. DATE OF DEATH MONTH DAY YEAR October 11, 1985			2b. HOUR 2:15 aM			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 18, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Baltimore Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Clerical	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 30 Dunvale Road 21204	
14. FATHER'S NAME FIRST MIDDLE LAST Purnell J. Warren, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lydia Sue Sibley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-03-2167		17. INFORMANT ADDRESS A. Warren Carroll 919 Starbir Road 21204					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary fibrosis								months	
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/18, 19 85 , to 10/11, 19 85 , that (I) (we) last saw the deceased alive on 10/11, 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Joel L. Hammer				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 10/11/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joel L. Hammer, M.D.				22e. ADDRESS 6701 N. Charles St. Baltimore MD 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 14, 1985		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.				ADDRESS 1050 York Road Towson, Md. 21204		25a. DATE REC'D. BY REGISTRAR OCT 15 1985		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

0700023

RECEIVED NOV 10 1962

UNITED STATES AIR FORCE
C-2



303103

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. CERTIFICATES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH CRIM. PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 5 27185	
1. DECEASED NAME (TYPE OR PRINT) C CHARLES EDWARD CARTER						2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR 10 22 1985		2b. HOUR ? M			
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 3 DAY 4 YEAR 1918	6. AGE (IN YEARS) LAST BIRTHDAY 67 YRS.	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN. 	2c. DATE PRONOUNCED DEAD 10 24 1985		2d. HOUR 10 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8562 Kavanagh Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bricklayer		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8562 Kavanagh Road 21222			
14. FATHER'S NAME FIRST Charles MIDDLE A. LAST Carter				15. MOTHER'S MAIDEN NAME FIRST Bessie MIDDLE C. LAST Summers							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-10-0029		17. INFORMANT Anna K. Carter		18. HUNTSMOORE ROAD BALTO., MD. 21227					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) SUDDEN DEATH DUE TO, OR AS A CONSEQUENCE OF (c) PROBABLE VENTRICULAR ARRHYTHMIA										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE J M NIELTUFF				TITLE (SPECIFY) M.D.				DATE SIGNED 10/27/85			
EXAMINER'S NAME (TYPE OR PRINT) J M NIELTUFF				ADDRESS 6800 mornington Ro. BALTO							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/27/1985		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN Baltimore COUNTY Maryland STATE Maryland					
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue Dundalk, Maryland 21222						25a. DATE REC'D. BY REGISTRAR OCT 28 1985		25b. REGISTRAR'S SIGNATURE [Signature]			

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REBEL MOTION



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FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 1 8 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Rev. Thomas W. Caulfield			2a. DATE OF DEATH MONTH DAY YEAR 10 5 85			2b. HOUR 10:30 a M	
1. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 6 20 07		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Johnstown, Penn.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Towson, Maryland BALTIMORE MD.	
10. CITY OR TOWN OF DEATH Towson Dulaney Valley		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) Stella Maris Hospice				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Priest	

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland			13c. COUNTY FREDERICK		13d. CITY OR TOWN Emmitsburg		13e. STREET ADDRESS / ZIP CODE 16120 Grotto Road 21727	
14. FATHER'S NAME FIRST MIDDLE LAST Phillip E. Caulfield			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Correll					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 220-44-9438-T		17. INFORMANT ADDRESS Mrs. Anne Matan (sister) 1 HENLOPEN AVE. REHOBOTH BEACH DEL.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a). Ca Prostate W/ Bony Metastasis

DUE TO, OR AS A CONSEQUENCE OF

(b) _____

DUE TO, OR AS A CONSEQUENCE OF

(c) _____

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>June 25</u> 19 <u>85</u> , to <u>October 5</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Eddie Nakhoda				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 8, 1985		23c. NAME OF CEMETERY OR CREMATORY ST. ANTHONY'S CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE Emmitsburg FREDERICK MD	
24. FUNERAL DIRECTOR NAME R. Lang Nightingale				ADDRESS Eckhardt Funeral Chapel OWINGS MILLS, MD		DATE REC'D. BY REGISTRAR 7 1985	
				REGISTRAR'S SIGNATURE John Davidson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed by the attending physician, and completed by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completed by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 4.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) NATALINA		FIRST Natalina		MIDDLE (nmn)		LAST CEMBROLA		2a DATE OF DEATH MONTH DAY YEAR 10 18 85		2b HOUR 6 AM	
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 24 '05		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) ITALY		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD					
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LITTLE SISTERS of the Poor		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY Own Home					
13a STATE New York		13b COUNTY Flushing		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 150-19 41st Avenue					
14 FATHER'S NAME FIRST MIDDLE LAST Guilo TABUCCI				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DARLI GAILDA							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b SOCIAL SECURITY NO. 220-46-0330		17 INFORMANT 2825 Munson St., Silver Spring, MD. Madeline Scholl (Daughter)							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Fever, Dehydration, Dementia											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from JUNE 3 , 19 70 , to OCTOBER 18 , 19 85 , that (I) (we) last saw the deceased alive on OCTOBER 17 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Baskaran				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10-18-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAMBANDAN BASKARAN				22e. ADDRESS 3455 Wilkens Ave BALTIMORE MD 21229							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 21 Oct. '85		23c. NAME OF CEMETERY OR CREMATORY Mt. St. Mary's Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Flushing, New York					
24 FUNERAL DIRECTOR NAME HUBBARD Funeral Home, Inc., 4107				ADDRESS Baltimore, Md. Wilkins Avenue				25a. DATE OF REGISTRATION OCT 21 1985			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. The purpose of this report is to provide a summary of the results of the survey conducted on the above described land.

2. The survey was conducted on the above described land.

3. The survey was conducted on the above described land.

4. The survey was conducted on the above described land.

5. The survey was conducted on the above described land.

6. The survey was conducted on the above described land.

7. The survey was conducted on the above described land.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 1 8 8

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edna B. Chapman				2a. DATE OF DEATH MONTH DAY YEAR 10 26 85				2b. HOUR 8 46 AM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 4 16 03		6. AGE (IN YEARS LAST BIRTHDAY) 82		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Concord, N.H.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. County MD.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Multi-Medical				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1320 Highland Dr. Balto. Md. 21239	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown Brown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) unknown NO		16b. SOCIAL SECURITY NO. 214-74-0714		17. INFORMANT ADDRESS Attys. 6721 Harford Rd. Stocksdales, Jarrell & Cvach, Balto. Md. 21234	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) senile dementia DUE TO, OR AS A CONSEQUENCE OF (c) senile dementia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from September 19 83 to October 26 19 85 , that (1) (we) last saw the deceased alive on October 25 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Carl S. Friedman M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/26/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carl S. Friedman, M.D.		22e. ADDRESS 660 Kenilworth Drive Towson, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10-28-85		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204		ADDRESS 1050 York Rd.		25a. DATE REC'D. BY REGISTRAR OCT 28 1985		25b. REGISTRAR'S SIGNATURE Christina Davidson			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and registered in the file by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card page 4 and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. If it is not so returned, it will be destroyed. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 5 2 7 1 8 9	
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH	
Irene Marie Chiofalo				10/3/85	
3. SEX		4. RACE		5. DATE OF BIRTH	
Female		White		February 24, 1915	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
Maryland		U.S.A.		70 YRS.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Towson		GBMC 6701 N Charles ST		Baltimore County MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Housewife		Own Home			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		--		Baltimore	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
John		Mattucci		Enes	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
No		215-05-1997		Frank J. Chiofalo	
				Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma					
DUE TO, OR AS A CONSEQUENCE OF (c) Endometrial primary					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/2 19 85, to 10/3 19 85, that (I) (we) last saw the deceased alive on 10/3 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Arthur W. Nauman MD				22c. DATE SIGNED 10/3/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. ARTHUR NAUMAN				22e. ADDRESS GBMC-6701 N. CHARLES ST. Baltimore, MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		10/7/85		Lorraine Park Cemetery	
				Woodlawn	
				COUNTY STATE	
				Maryland	
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, MD. 21228				25a. DATE REC'D. BY REGISTRAR OCT 4 1985	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Rondale	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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25M
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 (VR A15 ME (5))
1- FOR
STATE
REGISTRAR
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John Chrzanowski			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10 11 85		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 23 1928	6. AGE (IN YEARS) (LAST BIRTHDAY) 57 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 12 85
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD
10. CITY OR TOWN OF DEATH Essex		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7222 Stratton Way		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. COUNTY Balto.	13c. CITY OR TOWN Essex	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 7222 Stratton Way 21221	
14. FATHER'S NAME FIRST MIDDLE LAST John Chrzanowski			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophie Puczokowski		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 53-55		17. INFORMANT ADDRESS Deborah Airey 3308 Courtleigh Dr. 21207	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Neck injury</u> 8809 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR ? P.M. 10 11 85	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject fell down steps		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home	21f. LOCATION STREET CITY OR TOWN COUNTY STATE 7222 Stratton Way Essex Baltimore MD.		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Thomas D. Smith</i>		TITLE (SPECIFY) Acting Chief		DATE SIGNED 10/13/85	
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.		ADDRESS 111 Penn St. Balto. MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/16/85	23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Md.
24. FUNERAL DIRECTOR NAME ADDRESS Connelly Funeral Home 300 Mace Ave. 21221			25a. DATE REC'D. BY REGISTRAR OCT 16 1985		25b. REGISTRAR'S SIGNATURE <i>John Warden</i>

302015

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 1 9 1

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		JOHN WILSON CLARK		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
						10 23 85		17 19 M	
3 SEX		MALE		4 RACE		WHITE		5 AGE (IN YEARS LAST BIRTHDAY)	
						78 YRS			
6 BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Illinois		U.S.A.				Baltimore County MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Randallstown		Baltimore County General Hospital		Seaman		Marines			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Maryland				Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5503 W. North Avenue 21207	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
U N K N O W N		U N K N O W N							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT		ADDRESS			
No		261-24-4741		Pauline Swartz		529 Coventry Road 21229			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a)		Electromechanical dissociation							
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Acute myocardial infarction							
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:		Knd stage obstructive lung disease, COPD							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M.		19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>				STREET		CITY OR TOWN COUNTY STATE			
AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
		Hafeez Sued				10/23/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. ATTENDING PHYSICIAN		22g. MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
HAFEELZ SUEE		BALTIMORE COUNTY GEN HOSP		<input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		10/25/85		Meadowridge Mem. Park		Elkridge Howard Maryland			
24 FUNERAL DIRECTOR		24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR		24d. REGISTRAR'S SIGNATURE			
NAME		21229		OCT 25 1985		John Davidson Davidson			
Hubbard Funeral Home, Inc.		4107 Wilkens Avenue							

BP.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 1 9 2

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CLARENCE W. CLAWSON, SR.				2a. DATE OF DEATH MONTH DAY YEAR 10 16 85		2b. HOUR 1:20 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 03 18, 1912		6. AGE (IN YEARS, LAST BIRTHDAY) 73 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN) CANADA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE County MD.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired-Civil Engineer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md		13b. COUNTY BALTO		13c. CITY OR TOWN BALDWIN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Jesse H. Clawson, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophia Namon		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 217-18-6308		17. INFORMANT ADDRESS Clarence W. Clawson, Jr.-13400 Manor Rd. 21013					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) of Brain, Bone & Liver DUE TO, OR AS A CONSEQUENCE OF (c) Liver		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10-4 19 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 7600 OSLER Dr. Towson			
22a. I certify that (I) (this hospital) attended the deceased from 10-4 19 85 to 10-16 19 85 , that (I) (we) last saw the deceased alive on 10-16 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE A.M. Ghiladi		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-16-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.M. GHILADI, MD.		22e. ADDRESS 7600 OSLER Dr. Towson 21204					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-19-85		23c. NAME OF CEMETERY OR CREMATORY Moreland		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville Balto. Md.	
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.		ADDRESS 1050 York Rd.		25a. DATE REC'D. BY REGISTRAR OCT 18 1985		25b. REGISTRAR'S SIGNATURE <i>Gina Swanson-Randall</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 1 9 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Katherine E. Cohen			2a. DATE OF DEATH MONTH DAY YEAR October 5, 1985		2b. HOUR 3:05p.m.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 3 1903		
6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Telephone Operator-Western Union		
12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						
13b. COUNTY Baltimore		13c. CITY OR TOWN Edgemere		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 2908 Sparrows Point Road 21219						
14. FATHER'S NAME FIRST MIDDLE LAST Wilhelm Kopp		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Rumpel				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-09-2068		17. INFORMANT ADDRESS Irene Casale Same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac-Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Colonic Cancer With Metastasis DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 3, 1985 to October 5, 1985 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on October 5, 1985 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) (did not) view the body after death.						
22b. SIGNATURE D.L. Sanderson MD		DEGREE MD		22c. DATE SIGNED 10/5/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D.L. SANDERSON		22e. ADDRESS FRANKLIN SQUARE HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/9/1985		23c. NAME OF CEMETERY OR CREMATORY Meadowridge		
23d. LOCATION CITY OR TOWN COUNTY STATE Dorsey Howard Maryland						
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc.		ADDRESS 7922 Wise Avenue Dundalk, Maryland 21222		25a. DATE REC'D. BY REGISTRAR OCT 8 1985		
25b. REGISTRAR'S SIGNATURE Lelia Davidson-Randall						

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 1 9 4

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ROSE COHEN			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 9, 1985			2b. HOUR 9:30A.M.			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR APRIL 15, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3109 SHELburne RD. 21208				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. STATE MARYLAND			13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST LOUIS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SOPHIE CHERRY			13e. STREET ADDRESS / ZIP CODE 3109 SHELburne RD. 21208			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-32-9695D		17. INFORMANT ADDRESS MRS. SYLVIA MILLER 1 HIGH STEPPER CT. 21208 APT. 304					
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca of stomach & esophagus</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>									
19a. DATE OF OPERATION <u>4/15/85</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ca as above</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from <u>10/6</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) we (did) (did not) view the body after death.									
22b. SIGNATURE <u>Bernard Burgin M.D.</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>10/9/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD BURGIN			22e. ADDRESS 3809 CLARKS LA						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10/10/85		23c. NAME OF CEMETERY OR CREMATORY KNESSETH ISRAEL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215			25a. DATE REC'D. BY REGISTRAR OCT 15 1985			25b. REGISTRAR'S SIGNATURE <u>Guth Davidson-Randall</u>			

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/B4

(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician and completed in accordance with the instructions of the funeral director. The law requires that the death certificate be signed by the attending physician and completed in accordance with the instructions of the funeral director. The law requires that the death certificate be signed by the attending physician and completed in accordance with the instructions of the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions of the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Note: This should be filed within 72 hours after closure with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner's signature is required at this point.

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FOR COTTON 2007



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 1 9 5

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Anne Regina George Collins			2a. DATE OF DEATH MONTH DAY YEAR October 31, 1985		2b. HOUR 1:00 P
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 7, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.	
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Multi.-Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Interior Decorator		12b. KIND OF BUSINESS OR INDUSTRY Interior Design & Furnishings
13a. STATE Florida		13b. COUNTY Manatee	13c. CITY OR TOWN Bradenton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Ralph		15. MOTHER'S MAIDEN NAME Mary Wanch		13e. STREET ADDRESS / ZIP CODE Rte 2, Box 279, Apt. 82B #34202	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 144-14-7762		17. INFORMANT Son: Mr. Lynn M. Collins, 7741 Chapel Ridge Lutherville 21093	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Pancreatic Cancer - Metastatic

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 85 to 10/29 85, that (I) (we) last saw the deceased on 10/29 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body of the deceased.			
22b. SIGNATURE Alan M. Shorofsky, M.D.		22c. DATE SIGNED 10/31/85	22d. PHYSICIAN'S NAME (TYPE OR PRINT)
22e. ADDRESS 660 Kenliworth Dr., Towson, Maryland 21204		22f. MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11/4/85	23c. NAME OF CEMETERY OR CREMATORY St. Johnsville Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Canaheherie Montgomery N. Y
24. FUNERAL DIRECTOR NAME Martin D. Lawson, 10 W. Padonia Rd.		DATE REC'D. BY REGISTRAR NOV 01 1985	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 1 9 6

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Marjorie M. Collins		2a. DATE OF DEATH MONTH DAY YEAR Oct. 31, 1985		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 22, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. Co. MD.
10. CITY OR TOWN OF DEATH Edgewood	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1014 Hanson Rd. Edgewood, Md.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bus Driver,	12b. KIND OF BUSINESS OR INDUSTRY School
13a. STATE Maryland	13b. COUNTY A.A. Co.	13c. CITY OR TOWN Pasadena	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Alanzo Pack	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mable Brown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO. 217-22-4719		17. INFORMANT ADDRESS Mr. James Collins, Same as above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEIZURES DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC ADENOCARCINOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA OF LUNG				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from July 19 85 to present 19, that (I) (we) last saw the deceased alive on Oct 3 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.				
22b. SIGNATURE J C Downs MD		DEGREE		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN C DOWNS		22e. ADDRESS UNIVERSITY HOSP. 22 South Grove Baltimore 21217		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11/24/1985	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemt.	23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn, Balto. Co. Md.	
24. FUNERAL DIRECTOR NAME McCully Funeral Home, Pasadena, Md. 21122		25a. DATE REC'D. BY REGISTRAR NOV 01 1985	25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

2

279

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

SEIZURES

METASTATIC ADENOCARCINOMA
OF LUNG

on 2 July 88

John C. DOWNS

UNIVERSITY HOSP. 33 SOUTH ST.

290063

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST C.		MIDDLE Edmund		LAST Connelly		2a. DATE OF DEATH October 14, 1985		2b. HOUR 10:54A _M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR November 8, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD					
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) President		12b. KIND OF BUSINESS OR INDUSTRY Wiping Cloth Co.			
13a. STATE Maryland		13b. COUNTY Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 6004 Roland Ave. 21210					
14. FATHER'S NAME FIRST MIDDLE LAST John Joseph Connelly				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Marie Connelly							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 800-04-9676		17. INFORMANT ADDRESS Mrs. Gwen A. Connelly 6004 Roland Ave. 21210							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Maryland							
22a. I certify that (I) (this hospital) attended to the deceased from <u>Sept 28 85</u> to <u>Oct 14 85</u> that (I) (we) last saw the deceased alive on <u>Oct 14 85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated											
22b. SIGNATURE <u>William G. Helfrich MD</u>										22c. DATE SIGNED 10-15-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William G. Helfrich										22e. ADDRESS 5006 Roland Ave. 21210	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-16-85		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Lutherville Baltimore Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home 6500 York Road 21212						25a. DATE REC'D. BY REGISTRAR OCT 15 1985		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

27198

1. DECEASED NAME (TYPE OR PRINT) James L. R. Conners			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 10 8 19 85			2b. HOUR M 10:33 a		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 25, 1966	6. AGE (IN YEARS) LAST BIRTHDAY YRS. 19	IF UNDER 1 YR. MONTHS DAYS 19	IF UNDER 24 HRS. HOURS MIN. 19	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 8 19 85		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.		
10. CITY OR TOWN OF DEATH Perry Hall		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4408 Wynn Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Landscape worker		12b. KIND OF BUSINESS OR INDUSTRY Landscaping
13a. STATE Md.			13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 917 E. Linwood Ave. 21224		
14. FATHER'S NAME FIRST MIDDLE LAST Lloyd James Conner				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Judith Bacastow				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-94-7605		17. INFORMANT Judith Conner ADDRESS 917 S. Linwood Ave. Balto., Md. 21224			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9259 IMMEDIATE CAUSE (a) Electrocution DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:30 10 8 19 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject came into contact with electric wires			
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) yard		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4408 Wynn Road Perry Hall Balto MD.			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE Dennis F. Smyth M.D.			TITLE (SPECIFY) M.D. Assistant			DATE SIGNED 10/8/85		
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.			ADDRESS 111 Penn St. Balto.MD.					
23a. BURIAL, CREMATION, REMOVAL (SEE IF Y)			23b. DATE 10/12/85		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
24. FUNERAL DIRECTOR H. J. Schlander			25a. DATE REC'D. BY REGISTRAR OCT 10 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. RETAIN PAGE 4. SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17
(VR A15 ME (5))

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U.S.A.

Q7. E. Lincoln Ave.

Soledad

James

James

John

200-4-2000



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1- FOR STATE REGISTRAR		MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST	
FRANCIS XAVIER CONNOR							
2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR	
October 27 1985							
2b. HOUR		3P		M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)	
MALE		WHITE		JAN. 15, 1917		68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
WASHINGTON, D.C. U.S.A.						BALTIMORE COUNTY, MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
21204		1306 PUTTY HILL AVENUE		COMPUTER ANALYST FED. GOVT			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MARYLAND		BALTIMORE		21204		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
A. PAUL CONNOR		EUGENIE MARIE GABRIELLE		YES		215-05-3518	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION		20. AUTOPSY?	
THERESA M. CONNOR BALTO., MD 21204		PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Disease of Brain</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>15 yrs</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		22c. Actual Signature <u>Charles F. O'Donnell</u> Deputy Medical Examiner		22d. Date Signed <u>10/28/85</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		OCT. 31, '85		PARKWOOD CEMETERY		BALTIMORE CO., MARYLAND	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE REC'D. BY REGISTRAR	
WILLIAM E. JOHNSON		OCT. 28, 1985					

303082



WIND

CLUB HIBER



281096

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ELEANOR D. CORNER			2a. DATE OF DEATH MONTH DAY YEAR 10 1 85		2b. HOUR 10 ⁰⁵ PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 10, 1891	6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Cockeysville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Broadmead		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE MD			13b. COUNTY Balto.	13c. CITY OR TOWN Cockeysville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Richard H. Diggs			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary King		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 216 46 1359	17. INFORMANT ADDRESS 5419 Springlake Way Mrs. Ruth Williams, Balto., MD 21212		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Atherosclerotic Vascular Disease

DUE TO, OR AS A CONSEQUENCE OF

(b)

Advanced age

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a

Probable Multiple Infarct Arteriosclerosis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 3/27 19 81 to 10/1 19 85, that (1) (we) lost saw the deceased alive on 9/30 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did not) view the body after death.			
22b. SIGNATURE Robert Liberto	DEGREE MD.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 10-1-85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT LIBERTO		22e. ADDRESS 3508 Bank St Balto. 21224	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 10/3/85	23c. NAME OF CEMETERY OR CREMATORY Green Mount	23d. LOCATION CITY OR TOWN COUNTY STATE Balto., MD
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD		25a. DATE REC'D. BY REGISTRAR OCT 3 1985	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

283099

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Walter W. Cornwell			2a. DATE OF DEATH MONTH DAY YEAR October 3, 1985		2b. HOUR 3:56p M						
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3-24-1913		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin SQ. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Merchant Marine		12b. KIND OF BUSINESS OR INDUSTRY Seaman			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Baltimore		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7940 Belridge Rd. 21236		
14. FATHER'S NAME FIRST MIDDLE LAST Sydney Cornwell			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Luitgard Morba			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II					
16b. SOCIAL SECURITY NO. A 047-10-3988			17. INFORMANT Cambridge, Md. 21613 Jacqueline Moore 408 Glenburn Ave.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME - STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 1, 1985, to October 3, 1985, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 3, 1985, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.											
22b. SIGNATURE M. Vemury M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL PHYSICIAN <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED October 3, 1985			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Vemury, M.D.				22e. ADDRESS 9000 Franklin Square Drive 21237							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Cremation		Oct. 7, 1985		Greenmount Cemt.		Baltimore City MD.					
24. FUNERAL DIRECTOR Schimunek Fun'l Home 9705 Belair Rd.						25a. DATE REC'D BY REGISTRAR OCT 8 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

MEDICAL CERTIFICATION

7
9

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, pages 1 and 2, and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

50

289021

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

27202

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARY		FIRST EDNA		MIDDLE CRANDELL		LAST		2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> 10 9 1985		2b. HOUR 0600	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 8 16 1901	6. AGE (IN YEARS) LAST BIRTHDAY 84 YRS.	7a. IF UNDER 1 YR. MONTHS DAYS 10 9	7b. IF UNDER 24 HRS. HOURS MIN. 19 55	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 9 1985		7d. HOUR 1120		7e. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County		10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6753 Roberts Avenue	
12a. USUAL RESIDENCE (TYPE OF WORK) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 6753 Roberts Avenue		13f. CITY OR TOWN Dundalk		13g. STATE Maryland		13h. COUNTY Baltimore		13i. CITY OR TOWN Dundalk		13j. STATE Maryland	
14. FATHER'S NAME FIRST MIDDLE LAST Adelbert Fountain		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eleanor Mitchell		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-03-6027		17. INFORMANT Robert Crandell		17b. ADDRESS Same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute intracerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE J. Crossan O'Donovan		TITLE (SPECIFY) Deputy		MEDICAL EXAMINER				DATE SIGNED 10/9/85			
EXAMINER'S NAME (TYPE OR PRINT) J. CROSSAN O'DONOVAN		ADDRESS 2112 DUNDALK AVE., BALT., MD. 21222									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/12/1985		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial				23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, Maryland 21222				25a. DATE REC'D. BY REGISTRAR OCT 14 1985		25b. REGISTRAR'S SIGNATURE J. Davidson-Randall					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP_____

DHMH - 17

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281035

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARY ELIZABETH CREMEN			2a. DATE OF DEATH MONTH DAY YEAR 10-2-85			2b. HOUR 10:35 P.M.			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 03-14-07		6 AGE (IN YEARS LAST BIRTHDAY) 78		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE County MD.			
10 CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME MAKER		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md. 13b COUNTY BALTO. 13c CITY OR TOWN PARKVILLE			14 FATHER'S NAME FIRST MIDDLE LAST James Carter Cremen		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Veronica O'Neill				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 218-18-4577		17 INFORMANT Mrs. Eleanor C. Stegmaier ADDRESS 12 Airway Circle Towson, Maryland 21204					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest due to DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe chronic obstructive pulmonary DUE TO, OR AS A CONSEQUENCE OF (c) disease with respiratory failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **None**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Natividad D. de Leon, M.D.			DEGREE M.D.	22c. DATE SIGNED 10/2/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NATIVIDAD D. DE LEON			22e. ADDRESS C/O ST. JOSEPH HOSPITAL		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/5/85		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville Baltimore MD	
24 FUNERAL DIRECTOR Loring Byers Funeral Directors, Inc. NAME ADDRESS 8728 Liberty Road Randallstown, Maryland 21133				25a. DATE RECD. BY REGISTRAR OCT 4 1985		25b. REGISTRAR'S SIGNATURE J. Davidson-Randall	

C

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

230132



20% FOLLOW UP

311126

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5

2 7 2 0 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Alexander C. CREWS			2a. DATE OF DEATH October 19, 1985		2b. HOUR 2:35 a.m.
3. SEX Male	4. RACE White	5. DATE OF BIRTH Oct. 20, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Railroad Emp.	12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. CITY OR TOWN Baltimore	13c. STREET ADDRESS / ZIP CODE 4609 Glenarm Ave. 21206	
14. FATHER'S NAME FIRST MIDDLE LAST Charlie Crews		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Pierce			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] No		16b. SOCIAL SECURITY NO. 250-01-1305		17. INFORMANT ADDRESS Preston Crews Buckingham, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Squamous cell carcinoma of the lung DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10-3, 19-85, to 10-19, 19-85 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10-19, 19-85, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (d) <input checked="" type="checkbox"/> view the body after death.					
22b. SIGNATURE Joseph J. Gallo MD				22c. DATE SIGNED Oct 19, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph J. Gallo, M.D.				22e. ADDRESS 9000 Franklin Square Dr. 21237	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-21-85		23c. NAME OF CEMETERY OR CREMATORY Buckingham Com.Cem	
23d. LOCATION CITY OR TOWN COUNTY STATE Buckingham, Buckingham, Va.		24. FUNERAL DIRECTOR NAME ADDRESS Dunkum Funeral Home PO Box 24 Dillwyn, Va.			
25a. DATE REC'D. BY REGISTRAR Oct 30 1985		25b. REGISTRAR'S SIGNATURE Julia F. [Signature]			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

311138

RECEIVED
FEB 20 1963

W. J. F. I.



283134

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
ITEM NUMBER 136, PER: PH. CALL 10-10-85, D.W. 8 5 2 7 2 0 3 1- STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANK CUDNIK JR					2a. DATE OF DEATH MONTH DAY YEAR 10/ 02/ 85				
3. SEX MALE		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR 8 / 06 / 26		6. AGE (IN YEARS LAST BIRTHDAY) YRS 59		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore CO.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SPRING GROVE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND					13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		
14. FATHER'S NAME FIRST MIDDLE LAST FRANK CUDNIK					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY KUREK				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MARY DRIGGERS 709 OAKLEIGH BEACH RD. 21222		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Artery DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arteriosclerosis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Miguel A. Heredia					DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 10-2-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MIGUEL A. HEREDIA					22e. ADDRESS SPRING GROVE HOSPITAL CENTER				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/07/85		23c. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS CEM.		23d. LOCATION BALTIMORE		COUNTY MD.	
24. FUNERAL DIRECTOR NAME KACZOROWSKI FUNERAL HOME					25a. DATE REC'D. BY REGISTRAR OCT 8 1985				
25b. REGISTRAR'S SIGNATURE John Davidson-Rendall									

MEDICAL CERTIFICATION

DEPT 13

10-11-10



10-11-10

305078

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Claude Cullum			2a. DATE OF DEATH MONTH DAY YEAR October 23, 1985		2b. HOUR 8:35a_M		
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR March 7 1916		6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS. MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10 CITY OR TOWN OF DEATH ROssville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Middle River		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> **	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Cullum		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hazel McCubbin		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			
16b. SOCIAL SECURITY NO. 213-07- 7204		17. INFORMANT ADDRESS Betty Jane Cullum 3500 Bay Drive 21220					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (c) Adenocarcinoma of the lung DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Intracranial metastasis of adenocarcinoma							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that he (this hospital) attended the deceased from October 7, 1985 , to October 23, 1985 , that he (we) last saw the deceased alive on October 23, 1985 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) did not view the body after death.							
22b. SIGNATURE <i>K. Kitchen M.D.</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. Kitchen, M.D.				22e. ADDRESS 9000 Franklin Square Drive, 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/26/85		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Cemetery		23d. LOCATION (IF OTHER THAN CEMETERY) Middle River Balto. Md. STATE	
24. FUNERAL DIRECTOR NAME ADDRESS Connelly Funeral Home 300 Mace Ave. 21221				25a. DATE REC'D. BY REGISTRAR OCT 30 1985		25b. REGISTRAR'S SIGNATURE <i>John Rindell</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.
IMPORTANT: If item 21 is marked as item 18, it is a traumatic event, the medical examiner must be notified at once.

302078



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

27207

1- FOR
STATE
REGISTRAR

REG. NO.

283168

1. DECEASED NAME (TYPE OR PRINT) Joseph W. Cumberland			2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 10-5 1985		2b. HOUR M 12:30 a.m.
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 12/17/60	6. AGE (IN YEARS) (LAST BIRTHDAY) 24 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10-5 1985
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CHILD OF WHAT COUNTRY? Baltimore, Md.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) south of Exit 13 east lane			
12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Number		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md.		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 2016 Hickum St.		13f. CITY OR TOWN Baltimore			
14. FATHER'S NAME FIRST MIDDLE LAST George C. Cumberland Jr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mrs. J. L. Leland			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 7575 212-18-9005		17. INFORMANT ADDRESS 21223 St. Ruby Barrett 2016 Hickum St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Multiple Injuries					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.					
(b) DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:25xx 10-5 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) pedestrian struck by auto	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE south of Exit 13, east lane, Catonsville, Balto. Co., Maryland	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Dennis F. Smyth, M.D.		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER		DATE SIGNED 10-5-85	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St., Balto., Md. 21201			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE 10/9/85		23c. NAME OF CEMETERY OR CREMATORY Goulds Park Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Anne Arundel		23e. DATE REC'D. BY REGISTRAR OCT 8 1985		23f. REGISTRAR'S SIGNATURE John L. Davidson	
24. FUNERAL DIRECTOR Charles D. Stevens ADDRESS 1501 E. Federal Ave. Baltimore, Md.					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT



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296039

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 2 0 9

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John Hart Cunningham			2a. DATE OF DEATH MONTH DAY YEAR Oct. 18, 1985			2b. HOUR MIN. 5:45 A.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 28, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 84		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Spartansburg, S.C. - U.S.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.			
10. CITY OR TOWN OF DEATH Catonsville,		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Summit Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction Engineer-		12b. KIND OF BUSINESS OR INDUSTRY tion	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 708 Brookwood Ave. - 21229			
14. FATHER'S NAME FIRST MIDDLE LAST Edward -- Cunningham				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Eloise Green					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 242-05-0337		17. INFORMANT Catonsville, Md. 21228 Mrs. Marcheta C. Moon - 411 Oak Forest Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary edema DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Old age								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 1. Chronic Fibrosis of Right Pleural Effusion 2. CHF									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from 1973 to 10-17-85 , 19____, that (1) (we) last saw the deceased alive on 10-16-85 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature]				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Allan Perez, M.D.				22e. ADDRESS 1009 Frederick Rd 21228					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/21/85		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery - Balto., Maryland			23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR'S NAME Sterling Funeral Estate, P. A.				25a. DATE REC'D. BY REGISTRAR OCT 21 1985		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

220000



291018

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		IF UNDER 1 YEAR MONTHS DAYS	
Orville Glenn CURREY Sr.		October 10, 1985		7:30 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	IF UNDER 24 HRS. HOURS MIN.	
Male	White	MONTH DAY YEAR	77 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
W. Va.	USA		Baltimore County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Rossville	Franklin Square Hospital		Retired		Beth-Steel
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS / ZIP CODE	
Md.	Balto.	Essex	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	338 Magnolia Terrace 21221	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Earl Currey		Florence Davis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT		
no		234-10-0687	Orville Currey Jr. 9543 Bauer Ave. 21236		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) _____					
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Status post cerebrovascular accident; Crohn's disease; Congestive heart failure</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (a) (this hospital) attended the deceased from <u>Sept. 26</u> , 19 <u>85</u> , to <u>Oct. 10</u> , 19 <u>85</u> , that (b) (we) last saw the deceased alive on <u>Oct. 10</u> , 19 <u>85</u> , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<i>Gay Johnson</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Gay Johnson		9000 Franklin Square Dr., 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial		10/14/85	Bel Air Memorial		Bel Air Harford Md.
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Connelly Funeral Home		OCT 16 1985		<i>Julia Davidson Fordell</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed by the physician within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

150102

309040

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FREDERICK J. DAMMANN		2a. DATE OF DEATH MONTH DAY YEAR 10 30 85		2b. HOUR 12:55 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 6 23 22	
6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. COUNTY MD.		10. CITY OR TOWN OF DEATH TOWSON	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STEAM FITTER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST HERMAN L. DAMMANN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AGNES C. MAACKS		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO	
17. SOCIAL SECURITY NO. 216099505		18. INFORMANT FAMILY RECORDS		19. ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest. DUE TO, OR AS A CONSEQUENCE OF (b) intractable V.F.b. - acute MI and DUE TO, OR AS A CONSEQUENCE OF (c) shock severe CAD				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 10/30 , 19 85 to 10/30 , 19 85 , that (1) (we) lost saw the deceased alive on 10/30 , 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J. D. Antkowiak M.D.		DEGREE M.D.		22c. DATE SIGNED 10/30/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Nov. 2, 1985		23c. NAME OF CEMETERY OR CREMATORY Parkwood L.S.M.	
23d. LOCATION CITY OR TOWN COUNTY STATE Parkville BALTO. MARYLAND		24. FUNERAL DIRECTOR NAME ADDRESS EVANS CHAPEL OF MEMORIALS HARFORD RD.		25a. DATE REC'D. BY REGISTRAR NOV 01 1985	
25b. REGISTRAR'S SIGNATURE [Signature]					

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18, any injury, or other traumatic event, the medical examiner must be notified.

BP

AMOR

NOTICE



WILLIAM

288056

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH 10	DAY 04	YEAR 85	7b. HOUR 11:17 ^a _M
1. DECEASED NAME (TYPE OR PRINT)		FIRST Rose	MIDDLE Flynn	LAST Dargan			
3. SEX Female	4. RACE White	5. DATE OF BIRTH		MONTH 2	DAY 12	YEAR 03	
6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County		MD.	
10. CITY OR TOWN OF DEATH Cockeysville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Broadmead 13801 York Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Cockeysville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 13801 York Road 21203			
14. FATHER'S NAME		FIRST James	MIDDLE Joseph	LAST Flynn	15. MOTHER'S MAIDEN NAME		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 252-30-8264		17. INFORMANT ADDRESS J. Kelso, 114 W. Heather Rd., Bel Air, MD, 21014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA of Lung - possibly</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastasis from Breast</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CHF, COPD, h/o CVA</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4-6-84</u> , 19 <u>84</u> , to <u>10-4</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>10-4-85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Robert Liberto, MD.</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>10-4-85</u>	
22d. PHYSICIAN'S NAME (PRINT OR PRINT)		22e. ADDRESS					
<u>ROBERT LIBERTO, MD</u>		<u>3508 BANK ST</u>		<u>21224</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 11, 1985		23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gdns.		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford, Maryland	
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>J. Davidson-Randall</u>	
				OCT 10 1985			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.



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281098

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JAMES K DAUGHERTY JR			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 1 1985			2b. HOUR 6²⁶ AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 22 1931		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE County MD.	
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK) Broker / Sales Agent		12b. KIND OF BUSINESS OR INDUSTRY Seed	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James Krozer Daugherty Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Hilda Geller		13e. STREET ADDRESS? ZIP CODE 1129 Gypsy Lane West 21204			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS Carolyn M. Daugherty, 1129 Gypsy Lane West, Towson, Md. 21204			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive - Atherosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes mellitus, insulin dependent</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Nephrosclerosis with uremia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> <u>35 years</u> <u>3 years</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Urinary retention</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Oct 1 85			
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 30 1985</u> to <u>Oct 1 1985</u> , that (I) (we) last saw the deceased alive on <u>Sept 30 1985</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Wm Carl Ebeling MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-1-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM CARL EBELING, MD				22e. ADDRESS 7620 YORK RD TOWSON MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/3/85		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME Martin D. Lawson				25a. DATE REC'D. BY REGISTRAR OCT 2 1985		25b. REGISTRAR'S SIGNATURE <u>William D. Anderson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

27213

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH		2b. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		M	
SAMUEL DAVIS		10 11 85		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.
Male	White	MONTH DAY YEAR	MONTHS DAYS HOURS MIN		
		11 10 09	75 YRS.		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9b. CITIZEN OF WHAT COUNTRY?	9. BALTIMORE CITY OR COUNTY OF DEATH		10. DATE PRONOUNCED DEAD	
Maryland	USA	Baltimore County		10 12 85	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Eastpoint	8028 Lansdale	Dept. of Sanitation			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Md.	Balto.	Eastpoint	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	8028 Lansdale Rd. 21224	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. SOCIAL SECURITY NO.			
FIRST MIDDLE LAST	FIRST MIDDLE LAST	215-09-9693			
	Davis Gertrude	Mary P. Denner 8028 Lansdale Rd. 21224			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS			
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	215-09-9693	Mary P. Denner 8028 Lansdale Rd. 21224			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					
(b) PROBABLE CARDIAC ARRHYTHMIA					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
				CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiries <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Unknown <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
J.M. Niehoff		M.D.		10/12/85	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		BALTO. MD.	
J.M. NIEHOFF		6800 MORNINGTON RD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		10/15/85		Gardens of Faith	
23d. LOCATION (CITY OR TOWN)		23e. COUNTY		23f. STATE	
Rossville		Balto.,		Md.	
24. FUNERAL DIRECTOR NAME		24a. DATE REC'D. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Connelly Funeral Home 300 Mace Ave. 21221		OCT 16 1985		Lisa Davidson-Randall	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Genevieve May Day				2a. DATE OF DEATH MONTH DAY YEAR October 5, 1985				2b. HOUR 10:00 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 6 1892		6. AGE (IN YEARS LAST BIRTHDAY) 92		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Mt. Airy Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2133 Cedar Circle Dr. Balt. Md 21228				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY Howard		13c. CITY OR TOWN Mt. Airy		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Ellsworth Dayhoff				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST May Nusbaum		16. STREET ADDRESS / ZIP CODE 880 Long Corner Rd. 21771			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-74-2260		17. INFORMANT Edward E. Day		18. ADDRESS 2133 Cedar Circle Dr. Baltimore, Md. 21228			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ret. static multiple myeloma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> 19 <u>85</u> to <u>October</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>September</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death.									
22b. SIGNATURE <u>Charles R. Graham Jr.</u> MD				22c. DATE SIGNED Oct 5, 1985				22d. ADDRESS 259 Frederick Rd. Balt. Md 21228	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 8, 1985		23c. NAME OF CEMETERY OR CREMATORY Locust Grove		23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Airy, Frederick, Md.			
24. FUNERAL DIRECTOR Orin L. Molesworth, P.A., Damascus, Md.				25a. DATE REC'D. BY REGISTRAR OCT 8 1985		25b. REGISTRAR'S SIGNATURE <u>J. Davidson-Randall</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carpal permit. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (LAST OR FIRST)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
ALBERT		J.		DECKER, JR.				OCTOBER 1, 1985		3:05P M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
MALE		WHITE		JULY 28, 1941		44					
7a. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIAGE STATUS MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		U.S.A.				BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
ROSEDALE		13 CLIFFWOOD ROAD				BUILDING ENGINEER BANK					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
MARYLAND		BALTIMORE		ROSEDALE				13 CLIFFWOOD ROAD 21206			
14. FATHER'S NAME (FIRST MIDDLE LAST)				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)							
ALBERT J. DECKER, SR.				CATHERINE COOKERLY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
NO				219-38-2874		Wilma Decker 13 Cliffwood Road 21206					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Renal Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (1) the hospital attended the deceased from <u>8/22/85</u> to <u>8/22/85</u> that (2) I last saw the deceased alive on <u>8/22/85</u> and that in my opinion death occurred on the date and hour and from the causes stated above. (If physician did not view the body after death, so state.)											
22a. SIGNATURE <u>Myo Thant</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22b. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
DR. Myo Thant				9101 Franklin Square Drive Suite 305							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		10-05-85		Loudon Park Cemetery		Baltimore Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE RECD. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Hubbard Funeral Home, Inc. 4107 Wilkens Avenue				21229		OCT 4 1985		<u>John A. Kunda</u>			

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COMMUNICATIONS SECTION

OCT 10 1962

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mary Deoms			2a. DATE OF DEATH MONTH DAY YEAR 10/20/85			2b. HOUR 7:20 A		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR NOV. 25, 1892		
6. AGE (IN YEARS LAST BIRTHDAY) 92			7. IF UNDER 1 YEAR MONTHS DAYS YRS			8. IF UNDER 24 HRS. HOURS MIN. MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO. MD.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County		
10. CITY OR TOWN OF DEATH TOWSON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DULANEY VALLEY NUR. Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		
12b. KIND OF BUSINESS OR INDUSTRY			13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.			13b. CITY OR TOWN BALTO.		
13c. CITY OR TOWN BALTO. CO.			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 9009 HARFORD RD. 21234		
14. FATHER'S NAME FIRST MIDDLE LAST HERMAN BESSLING			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY LOWMAN			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		
16b. SOCIAL SECURITY NO. 213-34-6538-D			17. INFORMANT FAMILY RECORDS			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) POST CVA DUE TO, OR AS A CONSEQUENCE OF (b) Generalized ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) old age Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 5/17 19 84 to 10/20 19 85 , that (I) (we) lost saw the deceased alive on 10/9 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Handwritten Signature			DEGREE Handwritten Signature			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/21/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. KOETTER			22e. ADDRESS 7600 OSLER DR. S. 315					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE OCT. 22, 85			23c. NAME OF CEMETERY OR CREMATORY MOST HOLY REDEEMER		
23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. CITY MD.			23e. DATE REC'D. BY REGISTRAR OCT 22 1985					
24. FUNERAL DIRECTOR EVANS CHAPEL OF MEMORIES PARKVILLE								
25. REGISTRAR'S SIGNATURE Julia Davidson-Randall								

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

61765

288041

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD., 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. (SEE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH THE BODY. (SEE PAGE 5 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.)

BP

DNMH - 17
(VR A15 ME (3))
20M 4/82

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
ADOLPHINE E. DEROUAUX								OCT. 9 1985								9:30 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
FEMALE	WHITE	APRIL 12, 1907		78 YRS.						OCT. 9 1985						9:30 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
OHIO		U.S.A.				BALTIMORE COUNTY, MD.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
TOWSON		CARDINAL SHEHAN CENTER FOR AGING		SECRETARY		RAILROAD											
13a. STATE		13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
MARYLAND		BALTIMORE		TOWSON		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		CARDINAL SHEHAN CENTER		21204							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
HUBERT		JOSEPHINE ROSENFELD		NO		274-10-0026		HUBERT N. DEROVAUX		21204		9 AIRWAY CIRCLE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		CARDIAC ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		SUDDEN							
				DUE TO, OR AS A CONSEQUENCE OF		ASCVD				2+ YEARS							
				DUE TO, OR AS A CONSEQUENCE OF													
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		HOUR A.M. MONTH DAY YEAR															
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION													
WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED											
CHARLES F. O'DONNELL, M.D.		Deputy				10/9/85											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		7501 YORK ROAD		21204											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION											
BURIAL		OCT. 14, '85		ST. JOSEPH CEMETERY		COLUMBUS, OHIO											
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
WILLIAM E. JOHNSON		8521 LOCH RAVEN BLVD.				OCT 10 1985		Julia Davidson-Randall									

110000

3/20
3/20

3/20

John + Barbara Light



REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Shirley IRENE Diggs		October 5, 1985		4:37 p.m.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
FEMALE	WHITE	MONTH 07 DAY 22 YEAR 1925	60 YRS.	IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND	USA		Baltimore County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
ROSSVILLE	FRANKLIN SQUARE HOSPITAL		ACCT		CHESSIE RR
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
MD	BALTO	BALTO	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	5422 CYNTHIA TERRACE 21206	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST MIDDLE LAST			FIRST MIDDLE LAST		
HARRY -- BUNN			CATHERINE --- HAMMACK		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
NO n/a		216200211	JAMES E. DIGGS 5422 CYNTHIA TERRACE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiopulmonary Arrest					
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Congestive Heart Failure					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (X) (this hospital) attended the deceased from October 5, 19 85, to October 5, 19 85, that (X) (we) lost saw the deceased alive on October 5, 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.					
22a. SIGNATURE		DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED
Michael G. Taylor, MD					10/5/85
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
BURIAL	10/9/85	MEADOWRIDGE	ELKRIDGE HOWARD MD		
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
J. L. Wood		OCT 7 1985		J. L. Wood	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 4 may be retained by the funeral director, or, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, this means that the death was due to violence.

505041

930% COTTON FIBER

WIDE

WAVE

WAVE



WAVE

295066

ITEM NUMBER 130 PER.PH.CALL

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Katherine Lair Disney			2a. DATE OF DEATH MONTH DAY YEAR Oct. 14 1985			2b. HOUR 5:30 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 15 1904		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Cockeysville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland Masonic Home				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland			13c. COUNTY Balt		13d. CITY OR TOWN Cockeysville		13e. STREET ADDRESS / ZIP CODE CORKEYVILL MD 21030		
14. FATHER'S NAME FIRST MIDDLE LAST Horace W. Lair			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Thomas						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213 20 3263		17. INFORMANT ADDRESS Md. Masonic Homes, Cockeysville, Md. 21030					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke DUE TO, OR AS A CONSEQUENCE OF (b) Embolism DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.									
22b. SIGNATURE Paul M. Rivas				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10-15-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul M. Rivas				22e. ADDRESS Masonic Homes					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 15, 1985		23c. NAME OF CEMETERY OR CREMATORY Norrisville U.M. Church		23d. LOCATION CITY OR TOWN COUNTY STATE Norrisville, Harford Co., Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212				25a. DATE REC'D. BY REGISTRAR OCT 18 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

62045

298086

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Harold Chester Dix, M.D.		2a. DATE OF DEATH MONTH DAY YEAR 10 21 85		2b. HOUR 5⁵⁰ A.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR September 14, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nebraska	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.	
10. CITY OR TOWN OF DEATH Cockeysville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1505 Applecroft Lane, #21030		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physician		12b. KIND OF BUSINESS OR INDUSTRY Medical
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Cockeysville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Arlie Umphreys Dix		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alta May Bennett			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 212-16-0205		17. INFORMANT ADDRESS Cockeysville 21030	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pericardial Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Widespread Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) pericardial lung					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hours 4 year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Sept 19 84 to 10/21 19 85 , that (I) (we) last saw the deceased alive on 10/20 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Wilfred H. Townshend Jr MD		DEGREE MD		22c. DATE SIGNED 10/21/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILFRED H. TOWNSHEND JR		22e. ADDRESS 14 E EAGER ST BALTIMORE MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/24/85		23c. NAME OF CEMETERY OR CREMATORY Grace U. Meth. Ch. Cem. Cockeysville, Balto. Co.,	
24. FUNERAL DIRECTOR NAME Martin D. Lawson		ADDRESS 10 W. Padonia Road, Timonium		25a. DATE RECEIVED BY 00123 1985	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

296048

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) CATHERINE GERTRUDE DOLL			2a. DATE OF DEATH 10/18/1985 10 18 / 85		2b. HOUR 17:39 P M	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 03 23 1892		6 AGE (IN YEARS LAST BIRTHDAY) 93 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.
10 CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAINT JOSEPH HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE REFERENCE TO ADMISSION) 13b. STATE MD			13c. COUNTY BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST JOHN KREINER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET MOHR			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 18 4255		17. INFORMANT CLARENCE N. DOLL (SON) 4 HAPSBURG CT., BALTIMORE, MARYLAND 21234		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHF DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a ATRIAL FIBRILLATION C.R.F.						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 10/18/85, 1985, to 10/18/85, 1985, that (I) (we) lost saw the deceased alive on 10/18/85, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not need view the body after death.						
22b. SIGNATURE [Signature] DEGREE				22c. DATE SIGNED 10/18/1985		22d. PHYSICIAN'S NAME (TYPE OR PRINT) MESSER
22e. ADDRESS ST JES ER				22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 10/19/1985		23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND
24 FUNERAL DIRECTOR NAME WALTER BROOKS BRADLEY, :INC. DUNDALK, MD. 21222				25a. DATE REC'D. BY REGISTRAR OCT. 21 1985		25b. REGISTRAR'S SIGNATURE [Signature]

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Their please remove contact with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

206643

CATHERINE L. COLL

FEMALE WHITE

SAINT JOSEPH HOSPITAL

BALTIMORE

MAY 17 1948



RECEIVED

20% COLLISION

WINTERHILL

CLAYTON COUNTY

PERMITTING TODAY 1948 HOME 1801

VENTNORTH RD BALTO, MD

0-7-41 83

296115

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Eleanor Cockey Harris Dorsey			2a. DATE OF DEATH MONTH DAY YEAR October 18, 1985			2b. HOUR 5:00 A M				
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 12, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 204 E. Joppa Road, Apt #510				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrative Secretary		12b. KIND OF BUSINESS OR INDUSTRY Balto. Co. Bd. of Education		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Broadway Harris			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jeanette Cockey			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				
16b. SOCIAL SECURITY NO. 215-07-8815			17. INFORMANT ADDRESS Towson, Maryland 21204 J. Marshall Dorsey, Jr. 30 Burke Avenue							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARRYTHMIA DUE TO, OR AS A CONSEQUENCE OF (b) COR PULMONALE DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Obstructive Lung Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yr.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Chronic Bronchitis - Emphysema										
19a. DATE OF OPERATION 10/18/85			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:00 10/18/85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> (AT WORK) (AT HOME)			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 10 Warren Road, Cockeysville, Maryland					
22. I certify that (1) this hospital attended the deceased from 1985 to Oct-17 1985 , that (2) (we) lost sight of the deceased on 10/18/85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did not view the body after death.										
22a. SIGNATURE Ronald L. Broadwater			22b. PHYSICIAN'S NAME (TYPE OFFICIAL) Ronald L. Broadwater, M.D.			22c. ADDRESS 10 Warren Road, Cockeysville, Maryland 21030		22d. DATE SIGNED 10/21/85		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/21/85		23c. NAME OF CEMETERY OR CREMATORY Jessops U. Meth. Ch. Cem., Cockeysville, Balto. Co.,		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Martin D. Lawson			24b. ADDRESS 10 W. Padonia Road, Timonium			25a. DATE REC'D. BY REGISTRAR OCT 21 1985			25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or hospital official, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-paper Page 4 and it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the experimental procedures used to test the hypotheses. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous research, and a discussion of the implications of the findings. The final part of the report is a conclusion and a list of references.

2. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the experimental procedures used to test the hypotheses. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous research, and a discussion of the implications of the findings. The final part of the report is a conclusion and a list of references.

3. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the experimental procedures used to test the hypotheses. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous research, and a discussion of the implications of the findings. The final part of the report is a conclusion and a list of references.

4. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the experimental procedures used to test the hypotheses. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous research, and a discussion of the implications of the findings. The final part of the report is a conclusion and a list of references.

5. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the experimental procedures used to test the hypotheses. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous research, and a discussion of the implications of the findings. The final part of the report is a conclusion and a list of references.



302050

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
WALTER		DROBISZ		October 24, 1985		8:57 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
Male	White	April 1, 1920		65		YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland	U.S.A.			Baltimore County, MD			
11. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rossville	Franklin Square Hospital			Purchase Supervisor			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. STREET ADDRESS / ZIP CODE			
13a. STATE COUNTY				13b. STREET ADDRESS / ZIP CODE			
Maryland Baltimore				6000 Benton Height Ave. 21206			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Adam Drobisz		Olga Proc					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes		212-09-1279		Mrs. Mildred R. Drobisz Same as # 13c			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Multiple Sclerosis</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22b. SIGNATURE OF PHYSICIAN				DEGREE		22c. DATE SIGNED	
Gracito Patricio, M.D.				M.D.		10/24/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Gracito Patricio, M.D.				2926 E. Cold Spring Lane			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		10-28-85		Moreland		Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Leonard J. Ruck, Inc. Baltimore, Md.				OCT 25 1985		[Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their plates remove carbon copies. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

304085

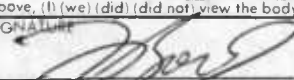
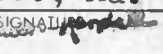
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Sister Mary Valentia Dvorak			2a. DATE OF DEATH MONTH DAY YEAR 10/23/85			2b. HOUR 6 A.M.			
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 3/5/03		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Czechoslovakia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Villa Assumpta, 6401 N. Charles				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Education	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Balto. 13c. CITY OR TOWN Baltimore					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6401 N. Charles St.		
14. FATHER'S NAME FIRST MIDDLE LAST Wenceslaus -- Dvorak					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Flidr				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-68-6378		17. INFORMANT ADDRESS S. Angelina Catina, 6401 N. Charles					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (b) ASUD DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from June 78 to October 23, 85 , that (I) (we) last saw the deceased alive on October 23, 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE 					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Lawrence Boas, M. D.					22e. ADDRESS 54 Scott Adam Rd., Cockeysville 21030				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/26/85		23c. NAME OF CEMETERY OR CREMATORY Villa Maria		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Arm, Balto., Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home, Inc., 6500 York Rd. Balto. Md 21212					25a. DATE REC'D. BY REGISTRAR OCT 29 1985		25b. REGISTRAR'S SIGNATURE 		

BP

309001

1- FOR
STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5

2 7 2 2 5

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <u>MARY</u>		FIRST MIDDLE LAST <u>Dziwulski</u>		2a. DATE OF DEATH MONTH DAY YEAR <u>10 / 28 / 85</u>		2b. HOUR <u>7³⁰ PM</u>	
3 SEX <u>FEMALE</u>		4 RACE <u>CAUC.</u>		5 DATE OF BIRTH MONTH DAY YEAR <u>10 / 17 / 90</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>95</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>POLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore</u> MD.	
10 CITY OR TOWN OF DEATH <u>Towson</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Stella Maris Hospice 2300 Dulaney Valley Rd</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>HOMEMAKER</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <u>MARYLAND</u>		13b. COUNTY <u>BALTIMORE</u>		13c. CITY OR TOWN <u>BALTIMORE</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS / ZIP CODE <u>2108 GOUGH STREET 21231</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO.		17 INFORMANT <u>4414 FRANKFORD AVE. 21206</u>		REV. MSGR. ANTHONY DZIWULSKI ST. ANTHONY'S CH.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular disease</u>							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>November 4, 19 85</u> , to <u>October 28, 19 85</u> , that (I) (we) last saw the deceased alive on <u>October 28, 19 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>K F Faulkner MD</u> DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>10/28/85</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Kendall Faulkner</u>		22e. ADDRESS <u>2300 Dulaney Valley Rd</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>10/31/85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY CEM.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>BALTIMORE, MARYLAND</u>	
24 FUNERAL DIRECTOR NAME <u>KACZOROWSKI FUNERAL HOME</u> ADDRESS <u>2525 FLEET ST. 21224</u>				25a. DATE REC'D. BY REGISTRAR <u>NOV 01 1985</u>		25b. REGISTRAR'S SIGNATURE <u>John Burdon-Kendall</u>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 27 22 26

1. FOR STATE REGISTRAR		REG. NO.	
DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR	
Margaret Edwards		October 13, 1985	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
Female	White	Dec. 11 1892	92 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MD.
Maryland	USA	Baltimore County	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Rossville	Franklin Square Hospital	Seamstress	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Md.	Balto.	Middle River	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
Simon Schaler		Justina Kunkel	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
no		213-09-2699	
17. INFORMANT ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Leaking abdominal aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic cardiovascular disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Cerebral vascular accident</u>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <u>October 5</u> 19 <u>85</u> to <u>October 13</u> 19 <u>85</u> , that (we) last saw the deceased alive on <u>October 13</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above at (we) (did) (and not) view the body after death.			
22b. SIGNATURE <u>Dr. Moushabek</u>		22c. DATE SIGNED <u>10/13/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Moushabek		22e. ADDRESS 9000 Franklin Square Drive, 21237	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Burial		10/17/85	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Holy Redeemer Cemetery		Baltimore City Md.	
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
Connelly Funeral Home 300 Mace Ave. 21221		OCT 16 1985 <u>John Anderson - J. Anderson</u>	

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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100% COTTON FIBER

1/1

290169

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 2 2 7

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LILLIAN ELFENBEIN			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 10, 1985			2b. HOUR 1 P. M.			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 18, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7904 BROOKHAVEN RD. 21207				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7904 BROOKHAVEN RD. 21207	
14. FATHER'S NAME FIRST MIDDLE LAST ISAAC KARP					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE UNKNOWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 800-00-2928		17. INFORMANT ADDRESS ISADORE ELFENBEIN 7904 BROOKHAVEN RD. 21207					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>aging</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>COPD</u>									
19a. DATE OF OPERATION <u>August 1985</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ca of uterus</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/17</u> , 19 <u>82</u> to <u>10/10</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>10/5</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Joseph C. Matcitar</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>10/11/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOSEPH C. MATCITAR</u>				22e. ADDRESS <u>3635 Old Court Road</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/11/85		23c. NAME OF CEMETERY OR CREMATORY OHEB SHALOM MEM.		23d. LOCATION CITY OR TOWN COUNTY STATE PARK REISTERSTOWN BALTO MARYLAND			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.				25a. DATE REC'D. BY REGISTRAR OCT 15 1985					
6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215				25b. REGISTRAR'S SIGNATURE <u>Lelia Davidson-Randall</u>					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

COLORES

20% COTTON BLEND
MADE IN U.S.A.



288072

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 2 7 2 2 8
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR			
John Henry Ellis			Oct. 8 1985			M			
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Male		White		March 24 1897		88		M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Virginia		USA				Baltimore County		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Lutherville		703 Chapel Ridge Rd., 21093				Contractor		Residential	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Maryland		Baltimore		Lutherville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		703 Chapel Ridge Rd., 21093	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
George Wales Ellis				Emma Jane Hubbard					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
No		-		227-01-9375 Oma E. Ellis, 703 Chapel Ridge Rd., 21093					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspirin Pneumonia</u>								days	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ESOPHAGEAL OBSTRUCTION</u>								weeks	
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>SEMI-LE DEMENTIA</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Harvey S. Mishner</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-9-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harvey S. Mishner, M.D.						22e. ADDRESS Warren Rd., Cockeysville, Md. 21030			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			10/10/85		Dulaney Valley Cem.		Timonium Balto. Md.		
24. FUNERAL DIRECTOR J. E. Lowell Lemmon, 10 W. Padonia Rd.						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
						OCT 10 1985			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove certificates 1 and 2 and place them in the folder provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause of death, the medical examiner must be notified at once.

BP _____

282075



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST LILLIAN M. ELY			MONTH DAY YEAR Oct. 2, 1985			a 6:00 M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Female	White	MONTH DAY YEAR June 2, 1889	96 YRS			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
MD	USA		Baltimore County MD					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Towson	Holly Hill Manor		Homemaker			Own Home		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
MD			Balto.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. STREET ADDRESS / ZIP CODE		
Simon J. Martinette			Mattie Lange			500 W. University Pkwy., 21210		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
No			217 32 8991			P.O. Box 201, 20860 James Hunter, Sandy Spring, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NO <input type="checkbox"/> WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (i) this hospital attended the deceased from <u>8/19</u> , 19 <u>85</u> , to <u>Oct</u> , 19 <u>85</u> , that (ii) (we) last saw the deceased alive on <u>8/19</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Stephen Laiken</u>			DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>10/2/85</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Stephen Laiken, MD			22e. ADDRESS 6805 York Road, Balto., MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., MD	
24. FUNERAL DIRECTOR NAME ADDRESS Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212					25a. DATE REC'D. BY REGISTRAR OCT 3 1985		25b. REGISTRAR'S SIGNATURE <u>Jana Davidson-Randall</u>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18, enter any injury, or other traumatic event, or other cause which may be indicated above.

E09225

301059

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 2 3 0

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WALTER E. ENGEL			2a. DATE OF DEATH MONTH DAY YEAR OCT. 22, 1985		2b. HOUR 1:59 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 26, 1910		
6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		6b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		
7a. CITY OR TOWN OF DEATH TOWSON		7b. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION ST. JOSEPH HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Store Keeper		12b. KIND OF BUSINESS OR INDUSTRY State of Md.		
10. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		
14. FATHER'S NAME FIRST MIDDLE LAST John H. Engel		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna P. Hinricksen				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II 215-72-7430		17. INFORMANT ADDRESS Joyce R. McIntyre-2503 Hillford Dr. 21234		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE GASTROINTESTINAL HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE DUODENAL ULCER DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Recent acute myocardial infarction						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (this hospital) attended the deceased from 10-22 19 85 , to 10-22 19 85 , that (I/we) last saw the deceased alive on 10-22 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.						
22b. SIGNATURE Maurice B. Furlong MD				22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MAURICE B FURLONG JR				22e. ADDRESS 7620 YORK ROAD TOWSON MD 21204		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-25-85		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		
23d. LOCATION CITY OR TOWN Balto.		COUNTY MD.		STATE		
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.		ADDRESS 1050 York Rd. Towson, Md. 21204		25a. DATE REC'D. BY REGISTRAR OCT 24 1985		
25b. REGISTRAR'S SIGNATURE [Signature]						

BP _____
DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon copy 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1940-1941 - 1942-1943

1944

1945-1946 - 1947-1948

1949-1950 - 1951-1952

1953-1954 - 1955-1956

1957-1958 - 1959-1960

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

311029

1. DECEASED NAME (TYPE OR PRINT) JULIE Lynn ENTSMINGER			2a. DATE OF DEATH MONTH 10 DAY 31 YEAR 85		2b. HOUR 6:20 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH 3 DAY 19 YEAR 76	6. AGE (IN YEARS LAST BIRTHDAY) 9	IF UNDER 1 YEAR MONTHS 0 DAYS 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD		
10. CITY OR TOWN OF DEATH Owings Mills	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rosewood Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.			13b. CITY OR TOWN Baltimore	13c. STREET ADDRESS 401 Cedar Hill Rd. 21225	
14. FATHER'S NAME FIRST Raymond MIDDLE Ellwood LAST Entsminger			15. MOTHER'S MAIDEN NAME FIRST Charmaine MIDDLE P. LAST Owen		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-86-9676	17. INFORMANT Baltimore, Md. 21225 Ray Entsminger 401 Cedar Hill Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory arrest DUE TO, OR AS A CONSEQUENCE OF: (b) Pre-existing mental retardation DUE TO, OR AS A CONSEQUENCE OF: (c) Slp feeding gastrostomy tube PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Chronic DTH Refractoriness					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> FOOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Deborah J. Anna		DEGREE		22c. DATE SIGNED 10-31-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SECCORD L. SOPRA		22e. ADDRESS ROSEWOOD CENTER OWINGS MILLS MD 21117			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11-2-85	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION CITY OR TOWN Glen Burnie COUNTY A.A. STATE MD	
24. FUNERAL DIRECTOR McGully Funeral Home		25a. DATE REC'D BY REGISTRAR NOV 05 1985		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be immediately filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

BP

311023

DATE

EMERGENCY

10-31-82



10-31-82

10-31-82

10-31-82

10-31-82

283104

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5

2 7 2 3 2

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOSEPHINE G. ESPOSITO			2a. DATE OF DEATH MONTH DAY YEAR October 2, 1985		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 1, 1900		6. AGE (IN YEARS (LAST BIRTHDAY)) 85	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.		
10. CITY OR TOWN OF DEATH Dundalk	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7229 Holabird Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tailor	12b. KIND OF BUSINESS OR INDUSTRY Clothing	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Dundalk	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 7229 Holabird Ave. 21222	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Garbo		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Angelina Lamartina			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-01-9215	17. INFORMANT ADDRESS Catherine DiIorio Same as # 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalised Metastases DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma breast DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: osteoarthritis, diverticulosis colon.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 3.28 19 84 to 10.2.85 19 85 , that (I) (we) lost saw the deceased alive on 10.2.85 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22a. SIGNATURE Sukh D. Aujla	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sukh D. Aujla, M.D.	22e. ADDRESS 5211 Harford Rd.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10-7-85	23c. NAME OF CEMETERY OR CREMATORY New Cathedral	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS Duda-Ruck Funeral Home, Inc. 7922 Wise Ave.		25a. DATE REC'D. BY REGISTRAR NOV 8 1985	25b. REGISTRAR'S SIGNATURE John F. Friedman		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

JOSEPHINE D. SHERIDAN

October 2, 1932

Female

White

June 1, 1930

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U.S.A.

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William County,

Marshall

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1932 Holston Ave. 21222

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Application

Application

No

21-1-1

Application

Rank as of 1932



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John D. Weller, Jr.

2111 Harford St.

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1-7-32

New England

William County, Maryland

One-Lock Funeral Home, Inc. 1932 Ave. 21222

1932 Ave. 21222

312159

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 2 3 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Bertha V Esslinger</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>October 29 1985</i>		2b. HOUR MIN. <i>9 20 A M</i>						
3. SEX <i>Female</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>7 13 1909</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>76</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>BALTIMORE</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTO. County MD.</i>					
10. CITY OR TOWN OF DEATH <i>Towson</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN A FACILITY, GIVE STREET ADDRESS) <i>St. Joseph's Hospital Towson</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Cashier</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Acme</i>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <i>MD</i>		13b. COUNTY <i>BALTO</i>		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>7900 OAKLEIGH Rd 21234</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Columbus Burke</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Bertha Porter</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>217-16-3077</i>		17. INFORMANT ADDRESS <i>J. Warren Esslinger 14 Dublin Drive 21093</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Arteriosclerotic CV Dis Severe peripheral vas. insufficiency.</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>7/6</i> 19 <i>85</i> to <i>10/29</i> 19 <i>85</i> , that (we) lost saw the deceased alive on <i>10/29</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) did (did not) view the body after death.											
22b. SIGNATURE <i>Lester A. Wall Jr.</i>				DEGREE <i>MD</i>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>10/29/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>LESTER A. WALL Jr., MD.</i>				22e. ADDRESS <i>76 20 York Rd. Towson MD 21204</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>11-1-85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Dulaney Mem. Gardens</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i>					
24. FUNERAL DIRECTOR NAME <i>Lassahn Funeral Home</i>				ADDRESS <i>7401 Belair Rd. BALTO. MD. 21236</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 1 1985</i>		25b. REGISTRAR'S SIGNATURE <i>James H. Anderson</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This permit must be submitted to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

621516

283102

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PAULINE E. EVANS			2a. DATE OF DEATH MONTH DAY YEAR 10/4/85			2b. HOUR 12³⁰ M				
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7-17-1897		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Valley View Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7822 Rockbourne Road , 21222	
14. FATHER'S NAME FIRST MIDDLE LAST Charles A. Powers				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura B. Ours						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 263-41-2699		17. INFORMANT Thelma Evans				ADDRESS Same as 13e	
MEDICAL CERTIFICATION 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - Organic Brain Id DUE TO, OR AS A CONSEQUENCE OF (b) Infected Bedsores DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the physician) attended the deceased from 9/7/84 to 10/4/85 that (I) (not last) saw the deceased alive on 10/2/85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.										
22b. SIGNATURE Vuong Nguyen			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/4/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VUONG NGUYEN			22e. ADDRESS 6331 Belair Rd Balt 21206							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/7/1985		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Bluefield West Virginia			
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue Dundalk, Maryland 21222						25a. DATE REC.D. BY REGISTRAR OCT 8 1985		25b. REGISTRAR'S SIGNATURE John P. ...		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified by phone.)

252105

252105

252105



296072

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5

2 7 2 3 5

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Eva E. Faber			2a. DATE OF DEATH MONTH DAY YEAR 10 18 85		2b. HOUR 6:10 A.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 15, 1897		
6. AGE [IN YEARS (LAST BIRTHDAY)] 87 YRS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, County MD.				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dulaney - Towson Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		
12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Maryland		13b. COUNTY Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Charles Warren		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma A. Holtz				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N		17. INFORMANT ADDRESS Charles F. Faber 8805 Fearn Ave. 21234		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						
PART I. DEATH WAS CAUSED BY:						
IMMEDIATE CAUSE (a) myocardial Failure						
DUE TO, OR AS A CONSEQUENCE OF						
(b) ASCVD						
DUE TO, OR AS A CONSEQUENCE OF						
(c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (I) (this hospital) attended the deceased from 5/21 19 81 , to 10/18 19 85 , that (I) (we) last saw the deceased alive on 10/16 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE George T. Gilmore M.D.		DEGREE		22c. DATE SIGNED 10/18/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. George Gilmore		22e. ADDRESS 1717 York Rd.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct 21 1985		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		
23d. LOCATION Balto.		COUNTY STATE County Md.				
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.		ADDRESS Balto. Md.		25a. DATE REC'D. BY REGISTRAR OCT 21 1985		
25b. REGISTRAR'S SIGNATURE John Davidson-Randall						

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

200000

Virginia

U.S.A.

Nov. 12, 1937

NY

Honorable

3200 Madison Ave. 21231

Belmont

Belmont

Holmes

A.

State

Belmont

Belmont

Charles F. Brady 3200 Madison Ave. 21231

NY



296091

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH TOLSON PAY 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A15 ME (5))
15M 7/76

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST JOHN		MIDDLE JOSEPH		LAST FAHERTY		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH October		DAY 17		YEAR 1985		HOUR 4:45	
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH 12 DAY 11 YEAR 23		6. AGE (IN YEARS) (LAST BIRTHDAY) 61 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		MONTH October		DAY 17		YEAR 1985	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD											
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST JOSEPH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER				12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION							
13a. STATE MD		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1605 NATURO ROAD 21204									
14. FATHER'S NAME FIRST James				MIDDLE JOSEPH		LAST FAHERTY		15. MOTHER'S MAIDEN NAME FIRST CLARA				MIDDLE SPICER				LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		(IF YES, GIVE WAR OR DATES) W.W. II		16b. SOCIAL SECURITY NO. 218-16-4990		17. INFORMANT ADDRESS H. LOUISE FAHERTY BALTIMORE, MD 21204											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <u>Coronary Insufficiency</u> (b) <u>and ASCVD</u> (c) <u>and ASCVD</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>2 1/2 yrs</u>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER				DATE SIGNED 10/17/85					
EXAMINER'S NAME (TYPE OR PRINT) CHAREES F. O'DONNELL, MD				ADDRESS 7501 YORK RD.				BALTIMORE, MD				823-3161					
3a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				3b. DATE OCT. 21, '85		3c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY				3d. LOCATION CITY OR TOWN BALTIMORE CO., MARYLAND				STATE			
24. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON				ADDRESS 8521 LOCH RAVEN BLVD.				25a. DATE REC'D. BY REGISTRAR OCT 21 1985				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

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287067

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 2 3 1

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELLIOTT - FANSLER			2a. DATE OF DEATH MONTH DAY YEAR 10 1 85			2b. HOUR AM PM 5:30 AM				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 2 17 14		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) FLA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. County MD.				
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST JOSEPH HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET / ELECTRONIC AID		12b. KIND OF BUSINESS OR INDUSTRY ELECTRONICS		
13a. STATE MD			13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 721 CAMBERLEY CIRCLE 21204	
14. FATHER'S NAME FIRST MIDDLE LAST Percival Elliott Fansler			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Scott							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-16-5205		17. INFORMANT ADDRESS Mrs. Phyllis Fansler - Same as #13					

II. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) <u>Congestive Heart failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u>		5 years	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic cs of the bladder</u>		2 years	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

MEDICAL CERTIFICATION

9a. DATE OF OPERATION 9-27-85		19a. CONDITION FOR WHICH OPERATION WAS PERFORMED obstruction of the colon		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his hospital) attended the deceased from <u>9-25-85</u> , 19 <u>85</u> , to <u>10-1-85</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>9-30-85</u> , 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Robert Terrer</u>		REGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10.1.85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PEMY CHITIM		22e. ADDRESS ROBERTO TERRER - 7600 Cedar Dr. - MD 21204					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 10/1/85		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
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24. FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR OCT 9 1985		25b. REGISTRAR'S SIGNATURE <u>Frederick W. Dandridge</u>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be recorded within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, pages 3 and 4 should be detached for use as the Burial Transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 2 3 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Samuel J. Farone			2a. DATE OF DEATH MONTH DAY YEAR 10.23.85		2b. HOUR 10:00A				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 15, 1913		6. AGE (IN YEARS LAST BIRTHDAY) YRS 72		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, County MD.			
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mason Tender		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. CITY OR TOWN Harford		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 2118 Oaklyn Drive 21047		
14. FATHER'S NAME FIRST MIDDLE LAST Ben Faraone			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria Scollo			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			
16b. SOCIAL SECURITY NO. 217-01-2570			17. INFORMANT ADDRESS Mrs. Stella LiPira Same						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I (this hospital) attended the deceased from 10/23 , 19 85 , to 10/23 , 19 85 , that I (we) lost saw the deceased alive on 10/23 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Purnushottam Nitra			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10.28.85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PURNUSHOTTAM NITRA			22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 26, 1985		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		
24. FUNERAL DIRECTOR NAME Leonard J. Rueck Inc. Baltimore, Maryland			25a. DATE REC'D. BY REGISTRAR OCT 25 1985		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP _____

303120

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 2 3 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mr. J. Carroll Feeney			7a. DATE OF DEATH MONTH DAY YEAR October 24 1985		2b. HOUR 12:30 P.M.
3 SEX Male	4 RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR May 12 1906	6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10 CITY OR TOWN OF DEATH Randallstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired - Lord	12b. KIND OF BUSINESS OR INDUSTRY Baltimore Press	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Woodstock	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Patrick A. Feeney			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST M. Blanche Murphy		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2		17. INFORMANT NAME ADDRESS Mrs. Margaret F. Cornwell 2841 Hernwood Rd. Woodstock Maryland 21163	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CA COLON, ACUTE RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: METASTASIS TO LIVER, SEPSIS					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 9/16 , 19 85 , to 10/24 , 19 85 , that (we) lost saw the deceased alive on 10/24 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE Purushottam Mitra			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10.24.85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PURUSHOTTAM MITRA			22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10-28-85	23c. NAME OF CEMETERY OR CREMATORY St. Alphonsus Church	23d. LOCATION CITY OR TOWN COUNTY STATE Woodstock Baltimore Maryland	23e. DATE OF REGISTRATION OCT 28 1985	
24. FUNERAL DIRECTOR NAME ADDRESS Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21133			25a. DATE OF REGISTRATION OCT 28 1985		

MEDICAL CERTIFICATION

FILED 3-1-53
MAR 1 1953
FBI - NEW YORK

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]
RE: [Illegible]

[Large block of illegible text, likely a body of a letter or report]

100-100000-100
MAR 1 1953
FBI - NEW YORK

295125

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN FELLAS			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 18, 1985			2b. HOUR M AM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 08, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KARAWAS, CYPRUS		7b. CITIZEN OF WHAT COUNTRY? GREECE		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH ARBUTUS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1137 LINDEN AVENUE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STONE MASON		12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN ARBUTUS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE FELLAS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIA SAMOUTAS			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (S, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
16b. SOCIAL SECURITY NO. 217-38-7084			17. INFORMANT ADDRESS MR. GEORGE FELLAS 1137 LINDEN AVENUE						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the kidney DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic obstructive lung disease, Congestive heart failure									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 19 82 to Present 19 _____ that (I) (we) last saw the deceased alive on 10/5 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Bruck R. McCurdy			DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10/14/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bruck R. McCurdy, M.D.			22e. ADDRESS 1311 Francis Ave., Balto., 21227						
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 10/21/85		23c. NAME OF CEMETERY OR CREMATORY GREEK ORTHODOX CEME.		23d. LOCATION CITY OR TOWN COUNTY STATE WOODLAWN BALTO. MD.		
24. FUNERAL DIRECTOR AMBROSE, INC 1328 SULPHUR SPRING ROAD 21227					25a. DATE REC'D. BY REGISTRAR OCT 18 1985				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON AVE., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



1281087

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5

2 7 2 4 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ROBERT FERGUSON			2a. DATE OF DEATH MONTH DAY YEAR 10 01 85			2b. HOUR 259 PM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 3 10 02		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2525 Arthur Ave Sykesville 21784	
14. FATHER'S NAME FIRST MIDDLE LAST John Ferguson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Shell						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-32-3078		17. INFORMANT ADDRESS Howard Ferguson - Sykesville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Ellis Mez MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/1/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ellis Mez MD			22e. ADDRESS 1425 Liberty Road Eldersburg, MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-4-85		23c. NAME OF CEMETERY OR CREMATORY Lake View Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Md.		
24. FUNERAL DIRECTOR NAME Harry W. Haight			ADDRESS Sykesville, MD			DATE REC'D. BY REGISTRAR OCT 3 1985		REGISTRAR'S SIGNATURE Julia Davidson-Randall	

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be attached for use at the burial/transit permit. Then please remove tabloids/papers. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10/15/52

REPORT

PERMISSION

NO 01 82 251

23

NO 01

3

WHITE

WHITE

BATHING COUNTRY

Actual

Between Camp Ground

Between Camp Ground

Between Camp Ground

Between Camp Ground

Between Camp Ground

John

John

John

John

515-25-208 John

ACUTE MYOCARDIAL INFARCTION

10/15/52

10/15/52

10/15/52

290003

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 2 4 2

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) RUSSELL FRANCIS FERGUSON			2a. DATE OF DEATH MONTH DAY YEAR 10 13 85			2b. HOUR 7¹⁰ PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 22, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 89	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) California		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. COUNTY MD.	
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) STELLA MARIS HOSPICE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver - News-American		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Marion FERGUSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW I			
16b. SOCIAL SECURITY NO. 212-10-6023		17. INFORMANT ADDRESS Lula C. Ferguson - Same as #13e					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

ADVANCED SCLEROTIC CARDIOVASCULAR DISEASE

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10-11 , 19 85 , to 10-13 , 19 85 , that (I) (we) lost saw the deceased alive on 10-13 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE EDDIE NAKHUDA				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDDIE NAKHUDA				22e. ADDRESS 2300 DULANEY VALLEY RD. TOWSON MD.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-16-85		23c. NAME OF CEMETERY OR CREMATORY Meadowridge		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. Towson, Md. 21204				25a. DATE REC'D. BY REGISTRAR OCT 15 1985		25b. REGISTRAR'S SIGNATURE <i>L. Davidson-Randall</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be immediately filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

500005

WILKINSON

PHOTO 300



8 5 2 7 2 4 3

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EVELYN C		FIRST MIDDLE LAST FISCHER		2a. DATE OF DEATH MONTH DAY YEAR OCT. 12, 1985		2b. HOUR 9A M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 20, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md		13b. COUNTY BALTO.		13c. CITY OR TOWN COCKEYSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William HESE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE BAUMGARTNER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 216-07-1074B		17. INFORMANT ADDRESS PAUL FISCHER JR. 10105 CHARING TON RD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Adenocarcinoma DUE TO, OR AS A CONSEQUENCE OF (b) Endometrial Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from October 8 , 19 85 , to October 12 , 19 85 , that (I) (we) lost the saw the deceased alive on October 12 , 19 85 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I and did not view the body after death.)							
22b. SIGNATURE Charles Hutton		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/12/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES HUTTON		22e. ADDRESS 7600 OSLER DR TOWSON MD 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCT. 14, 1985		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.	
24. FUNERAL DIRECTOR NAME HARTLEY MILLER		ADDRESS 7527 HARFORD RD.		25a. DATE REC'D. BY REGISTRAR OCT 14 1985		25b. REGISTRAR'S SIGNATURE J. P. Kauder, Registrar	

166

297131

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 2 4 4

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Ernest</u> MIDDLE <u>Granville</u> LAST <u>Fleischmann</u> Ernest Fleischmann				2a. DATE OF DEATH MONTH DAY YEAR October 21, 1985				2b. HOUR 4:36 A.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 17 18		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE THE WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Exxon Corp.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Rosedale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Ernst Fleischmann				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Eva Taylor					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-05-5278		17. INFORMANT ADDRESS Frances M. Fleischmann 8308 Karl Ave. 21237					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Oct. 21</u> , 19 <u>85</u> , to <u>Oct. 21</u> , 19 <u>85</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Oct. 21</u> , 19 <u>85</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.									
22b. SIGNATURE <u>James Doyle</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10/21/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James Doyle, MD				22e. ADDRESS 9000 Franklin Square Dr., 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-24-85		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville, Balto. Co., Md.			
24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc.				ADDRESS 6224 Eastern Ave.		25a. DATE REC'D. BY REGISTRAR OCT 22 1985		25b. REGISTRAR'S SIGNATURE <u>John E. Fisher</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies 4 and 5 and 7 and 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

BP

[illegible]

301015

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 2 4 5

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELLA CATHERINE FOOTE			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 21, 1985		2b. HOUR P 5:15 M					
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEB. 9, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD				
10. CITY OR TOWN OF DEATH DUNDALK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOW IN CARE OF GOVT. HOSPITAL, GIVE ADDRESS) 2 MARINA PARK DRIVE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY BALTO.		13c. CITY OR TOWN DUNDALK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2 MARINA PARK DRIVE 21222	
14. FATHER'S NAME FIRST MIDDLE LAST LEO P. NOEL			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADA ELIZABETH WESTBROOK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 219.01.4410		17. INFORMANT ADDRESS JOHN C. FOOTE (HUSBAND) (SAME AS 13e)					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA LUNG WITH METASTASIS DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 6-18 , 19 84 , to 10-21 , 19 85 , that (I) (we) last saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Savinder K Julka				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/22/1985		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAVINDER K JULKA				22e. ADDRESS 2900 DUNMANWAY, DUNDALK, MD. 21222						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 10/23/1985		23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND				
24. FUNERAL DIRECTOR NAME WALTER BROOKS BRADLEY INC., DUNDALK, MD. 21222				25a. DATE REC'D. BY REGISTRAR OCT 24 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodgers				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be immediately filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

30102

283159

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Grace Brown Fischer Jenkins Callahan Forbes</i>			2a. DATE OF DEATH MONTH DAY YEAR 10 08 '85		2b. HOUR 1a. M.
3. SEX <i>Female</i>	4. RACE <i>Caucasian</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>October 24, 1914</i>		6. AGE (IN YEARS LAST BIRTHDAY) 71 years old	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE COUNTY</i> MD.		
10. CITY OR TOWN OF DEATH <i>TOWSON</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF WORK IN SUCH FACILITY, GIVE STREET ADDRESS) <i>GBMC-6701 N. CHARLES ST.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13a. STATE <i>Maryland</i>	13b. CITY OR TOWN <i>Carroll</i>	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE <i>3947 Sykesville Rd. Rt. 2 21048</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Richard Worthward Fischer</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ella Spotswood Redd</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>218-07-8356</i>	17. INFORMANT ADDRESS <i>Frank B. Jenkins III 4367 Poole Road Finksburg, MD 21048</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIORESPIRATORY ARREST</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HRS.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>METASTATIC OAT CELL CA-LUNG</i> DUE TO, OR AS A CONSEQUENCE OF (c)					MONTHS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>9/09</i> 19 <i>85</i> , to <i>10/08</i> 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>10/08</i> 19 <i>85</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE <i>Joanne Wernicki</i>				22c. DATE SIGNED 10/08/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOANNE WERNICKI, M.D.				22e. ADDRESS GBMC-6701 N. CHARLES ST.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>October 10, 1985</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Calvary</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Gamber Carroll Maryland</i>		23e. DATE REC'D. BY REGISTRAR OCT 8 1985			
24. FUNERAL DIRECTOR NAME ADDRESS <i>Loring Byers Funeral Directors, INC. 8728 Liberty Road Randallstown, MD 21133-4784</i>				25. REGISTRAR'S SIGNATURE <i>Gaila Hamilton</i>	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 2 4 7

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EVELYN M. FOSLER			2a. DATE OF DEATH MONTH DAY YEAR October 1, 1985		2b. HOUR 5:45P M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 9, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 72	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Randallstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Designer	12b. KIND OF BUSINESS OR INDUSTRY Clothing	
13a. STATE Maryland		13b. COUNTY --	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3 East 33rd Street 21218
14. FATHER'S NAME FIRST MIDDLE LAST Cornelius Conklin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Dandridge			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-05-7814A		17. INFORMANT Apt. 1507 1101 St. Paul Street Charles W. Fosler III Baltimore, MD. 21202	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Acute on chronic renal failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

Aneurysm, old left cerebrovascular accident with right hemiparesis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8-23-1985 to 10-1-1985, that (I) (we) last saw the deceased alive on 10-28-1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) sign the body after death.			
22b. SIGNATURE S.D. AUJLA		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S.D. AUJLA		22e. ADDRESS M.D. 5460 OLD COURT ROAD RANDALLSTOWN MD 21133	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/5/85	23c. NAME OF CEMETERY OR CREMATORY Lakeview Memorial Park	23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll MD.
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke 1630 Edmondson Avenue, Catonsville, MD. 21228		25a. DATE REC'D. BY REGISTRAR OCT 4 1985	25b. REGISTRAR'S SIGNATURE Jana Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon and return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the event.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 2 4 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Warren A FOSTER			2a. DATE OF DEATH MONTH DAY YEAR October 8 1985		2b. HOUR MIN. 6:00p
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11 11 1920		6. AGE (IN YEARS LAST BIRTHDAY) YRS 64	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Rossville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Sqaure Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor	12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel	
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Dundalk	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 615 S. 48th Street 21224	
14. FATHER'S NAME FIRST MIDDLE LAST Richard Alfred Foster		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Owens			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) Yes WW II		16b. SOCIAL SECURITY NO. 212-18-3164	17. INFORMANT ADDRESS Jacqueline M. Perdue 828 Joppa Farm Road Joppa, MD. 21085		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Septic shock ; multiple emboli DUE TO, OR AS A CONSEQUENCE OF (c) Disseminated intravascular coagulation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Severe chronic obstructive pulmonary disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 4 1985 to October 8 1985 that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on October 8 1985 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) (did not) view the body after death.					
22b. SIGNATURE David Breitman		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/8/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Breitman		22e. ADDRESS F.S.H.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/14/1985	23c. NAME OF CEMETERY OR CREMATORY Garrison Forest	23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills Maryland		
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc.		ADDRESS 7922 Wise Avenue Dundalk, Maryland 21222		25a. DATE REC'D. BY REGISTRAR OCT 12 1985	25b. REGISTRAR'S SIGNATURE [Signature]

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified if possible.

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1- STATE REGISTRAR 11/14/85 rja

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 27 2 4 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MAUDE THELMA FRISBIE			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 20, 1985		2b. HOUR 6:05A M	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 1, 1897		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 82 88 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
10. CITY OR TOWN OF DEATH Cockeysville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland Masonic Homes		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST William Franklin Sothoron			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Pearl			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-54-6971		17. INFORMANT ADDRESS Records-Maryland Masonic Homes		
18. CAUSE OF DEATH (Enter only one cause per line for a), b), and c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Dementia						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Paul Rivas				22c. DATE SIGNED 10-21-85		
22d. PHYSICIAN NAME (TYPE OR PRINT) Paul Rivas, M.D.				22e. ADDRESS Cockeysville, Md. 21030		
23a. BURIAL, CREMATION, REMOVAL (SPEC) Burial		23b. DATE Oct. 22, 1985		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc.		ADDRESS Balto., Md. 21212		25a. DATE REC'D. BY REGISTRAR OCT 22 1985		
25b. REGISTRAR'S SIGNATURE John Davidson-Randall						

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE-MARYLAND 21201

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291028

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 2 5 0

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary M. Furlow			2a. DATE OF DEATH MONTH DAY YEAR October 11, 1985		2b. HOUR 6:00 PM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR May 27, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Catonsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ticket-Taker	12b. KIND OF BUSINESS OR INDUSTRY Theater	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Catonsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Joseph John Martin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Louisa Wiley		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A	17. INFORMANT Mrs. Antoinette Schatz	ADDRESS 9 Arbutus Ave. Balto, MD 21228		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardio Vascular DUE TO, OR AS A CONSEQUENCE OF (b) Heart Failure with Congestive Heart Failure & renal DUE TO, OR AS A CONSEQUENCE OF (c) Pericarditis DEHYDRATION PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITIONS GIVEN IN PART 1 (a) Cerebral Ischemia					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years. Aug 1985
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 10/2/85 to 10/11/85 that (I) (we) lost saw the deceased alive on 10/2/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (each) did not view the body after death.					
22b. SIGNATURE William E. McGrath		DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/14/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William E. McGrath, M.D.			22e. ADDRESS 1303 Frederick Rd. Balto., MD 21228		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/15/85	23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Lancaster, Lancaster, PA		
24. FUNERAL DIRECTOR ADDRESS MacNabb Funeral Home Catonsville, MD			25a. DATE REC'D. BY REGISTRAR OCT 16 1985		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 27251

1. DECEASED NAME (TYPE OR PRINT) Stella		MIDDLE Garczynski		LAST		2a. DATE OF DEATH MONTH DAY YEAR 10 - 09 - 85		7b. HOUR 9:10 a.m.	
3. SEX Female		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR 02 - 19 - 10		6. AGE (IN YEARS LAST BIRTHDAY) 75		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE Co MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dulaney Towson Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME MAKER		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 806 S. PORT ST 21224	
14. FATHER'S NAME FRANK		MIDDLE LEWANDOWSKI		LAST JOSEPHINE		15. MOTHER'S MAIDEN NAME NADOLNY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 217-01-9035		17. INFORMANT MR. MELVIN GARCZYNSKI		ADDRESS 3110 WINCHESTER WAY FALLSTON			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ischemic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Coronary artery insufficiency									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) d cerebro vascular accident Diabetes mellitus									
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR None 1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) None					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) None		21f. LOCATION STREET CITY OR TOWN COUNTY STATE None					
22a. I certify that (I) (this hospital) attended the deceased from Sept 30, 1984, to 9/30, 1985, that (I) (we) last saw the deceased alive on Sept 30, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE A-F NOUR MD		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A-F NOUR MD		22e. ADDRESS Balt MD 3901 Fleet St							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/12/85		23c. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.			
24. FUNERAL DIRECTOR NAME KACZOROWSKI FUNERAL HOME		ADDRESS 3525 Fleet St.		25a. DATE REC'D. BY REGISTRAR 10/14/85		25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician only, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Joseph Franklin Garver, Sr.			2a. DATE OF DEATH MONTH DAY YEAR Oct. 11 1985			2b. HOUR M 11			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 19 1906		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10 CITY OR TOWN OF DEATH Cockeysville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 400 Wake Robin Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Deputy Collector		12b. KIND OF BUSINESS OR INDUSTRY US Customs Civil Service	
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Cockeysville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Frank M. Garver			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Hester Little			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			
16b. SOCIAL SECURITY NO. WW II			17. INFORMANT 21776			ADDRESS 2632 Marston Rd. Diane K. Callaghan, New Windsor, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF ESOPHAGUS DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from 9.23 , 19 85 , to 10.4 , 19 85 , that (1) (we) lost saw the deceased above 10.7 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)									
22b. SIGNATURE Kleeman			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-11-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James C. Kleeman, M.D.			22e. ADDRESS Osler Drive, Towson, Md. 21204						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/14/85		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville Balto. Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Martin D. Lawson Martin D. Lawson, 10 W. Padonia Rd.						25a. DATE REC'D. BY REGISTRAR OCT 14 1985		25b. REGISTRAR'S SIGNATURE ne Davidson-Randall	

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1983

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 2 5 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELIZABETH LEATITIA GELBACK			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 7, 1985		2b. HOUR 7:55A ^M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 24, 1961	6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County ^{MD.}		
10. CITY OR TOWN OF DEATH Owings Mills	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baptist Home of Maryland		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Biologist	12b. KIND OF BUSINESS OR INDUSTRY Yale University	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 524 N. Charles St. 21201	
14. FATHER'S NAME FIRST MIDDLE LAST George Leroy Gelback		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leatitia Ellermeyer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 190-26-6220	17. INFORMANT ADDRESS Records-Baptist Home of Md. Owings Mills, Md.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES
DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE		YEARS
DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSION		YEARS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from June 1, 19 84 to Oct 7, 19 85, that (I) (we) saw the deceased alive on Sept 19, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE John G. Lavin	DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 10-7-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John G. Lavin, M.D.		22e. ADDRESS 6805 York Rd. Baltimore, Md. 21212	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Oct. 9, 1985	23c. NAME OF CEMETERY OR CREMATORY Woodlawn	23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn, Balto. Co., Md.
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24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212	25a. DATE REC'D. BY REGISTRAR OCT 9 1985	25b. REGISTRAR'S SIGNATURE John G. Lavin
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FAY FAY		2a. DATE OF DEATH MONTH DAY YEAR 10-14-85		2b. HOUR 3:45 P.	
3. SEX Female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 10-15-1903		6. AGE (IN YEARS (LAST BIRTHDAY)) 81 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH RANDALLSTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GEN. HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME
13a. STATE MARYLAND			13b. COUNTY BALTO.		13c. CITY OR TOWN BALTIMORE
14. FATHER'S NAME FIRST MIDDLE LAST LOUIS SAYE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA SIDLIN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 226-42-2904		17. INFORMANT GERALD GELFAND 14 GATES AVE. PLAINVIEW, NY 11803	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Sepsis; ? Etiology</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/14, 1985</u> to <u>10-14, 1985</u> that (I) (we) lost saw the deceased alive on <u>10-14, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Allen J. Chircus M.D.</u>				22c. DATE SIGNED 10-14-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Allen J. Chircus M.D.				22e. ADDRESS Baltimore County General Hosp	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCT. 16, 1985		23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		23e. NAME OF CEMETERY OR CREMATORY			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR OCT 21 1985	
25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>				25c. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

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TO HOSPITAL FOR ATTENDING PHYSICIAN. The low requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Frank GENTILE			2a. DATE OF DEATH MONTH DAY YEAR October 13, 1985			2b. HOUR 3:51a M					
3. SEX MALE		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 2 7 1927		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) City of Balto Bureau of Parks		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2503 Bauernschmidt Drive 21221		
14. FATHER'S NAME FIRST MIDDLE LAST Salvatore GENTILE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Concetta Sparacino			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 215-28-8481	
17. INFORMANT ADDRESS 21221			17. INFORMANT ADDRESS 21221			17. INFORMANT ADDRESS 21221				17. INFORMANT ADDRESS 21221	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) POSSIBLE ACUTE MYOCARDIAL INFARCT DUE TO, OR AS A CONSEQUENCE OF (b) POSSIBLE PULMONARY EMBOLISM DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 13, 1985 to October 13, 1985 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 13, 1985 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated <input checked="" type="checkbox"/> (we) view the body after death.											
22b. SIGNATURE Madura L. Prabhakar						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22a. PHYSICIAN'S NAME (TYPE OR PRINT) Madura L. Prabhakar, M.D.						22e. ADDRESS 3413 East Lombard Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10-16-85			23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer			23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		
24. FUNERAL DIRECTOR NAME Joseph N. Zannino						24b. ADDRESS 263 S. Conkling St.			25a. DATE REC'D. BY REGISTRAR OCT 15 1985		
25b. REGISTRAR'S SIGNATURE John Davidson						25c. REGISTRAR'S SIGNATURE John Davidson					

BP
DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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CHIEF OF POLICE

FOX GILSON FILE

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OCT 13 1960

305128

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 2 5 6

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marybelle Gera			2a. DATE OF DEATH MONTH DAY YEAR October 20, 1985		2b. HOUR MIN. 4:20p		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 3 1909		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 76	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County	
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Ho spital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaking	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN NOT		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Valentine Bentzel		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Cole		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-09-9696-D	
17. INFORMANT ADDRESS Marie Heinfield 7913 Elmhurst Ave. 21237							

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Cardiopulmonary Arrest**

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Bleeding Esophageal Veins**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Cirrhosis of Liver of Unknown Etiology**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (X) this hospital attended the deceased from October 19 85 , to October 20 85 , that (we) last saw the deceased alive on October 20 19 85 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.							
22b. SIGNATURE Marlene J. Zetzer		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/20/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARLENE J. ZETZER		22e. ADDRESS 9000 Franklin Square Drive 21237					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-23-85		23c. NAME OF CEMETERY OR CREMATORY Zion Luth.Ch.Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home		ADDRESS 7401 Belair Rd. Bkto. MD. 21236		25a. DATE REC'D. BY REGISTRAR OCT 28 1985		25b. REGISTRAR'S SIGNATURE John T. ...	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



295037

1-
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 2 5 7

REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST Francis (Jr. - GARAHY) GERAHTY Jr.			2a. DATE OF DEATH MONTH DAY YEAR October 17, 1985		2b. HOUR 1:25p M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 09 22 1911		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH ROSSVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TOOLS		12b. KIND OF BUSINESS OR INDUSTRY MANUFACTURE
13a. STATE MD		13b. COUNTY BALTO	13c. CITY OR TOWN ROSEDALE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1515 NEIGHBORS AVE 21237
14. FATHER'S NAME FIRST MIDDLE LAST FRANCIS GERAHTY Sr			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATHERINE --- ---		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WWII		16b. SOCIAL SECURITY NO. 218073061	17. INFORMANT ADDRESS DENNIS GERAHTY 1515 NEIGHBORS AVE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Possibly secondary to Meningioma or Ruptured Aneurysm DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 17, 1985 , to October 17, 1985 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 17, 1985 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did not) view the body after death.					
22b. SIGNATURE K.C. Kitchen M.D.		DEGREE M.D.		22c. DATE SIGNED 10-17-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K.C. Kitchen, M.D.		22e. ADDRESS 9000 Franklin Square Dr., 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 10/21/85	23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST		23d. LOCATION CITY OR TOWN COUNTY STATE REISTERSTOWN BALTO MD	
24. FUNERAL DIRECTOR NAME Charles R. R...		ADDRESS 1214 ...		25a. DATE REC'D. BY REGISTRAR OCT 18 1985	25b. REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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10/10/80

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5

2 7 2 5 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES HOWARD GERBEN, Sr.			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 10, 1985		2b. HOUR A 2:20 M		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEBRUARY 4, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PATIENT		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN Edgemere		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Albert GERBEN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Armon		13e. STREET ADDRESS / ZIP CODE 2515 EUGENE AVENUE		21219	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 216 16 3125		17. INFORMANT CLINICAL RECORDS, VANC, FORT HOWARD, MD		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RENAL FAILURE, ACUTE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) POSSIBLE RENAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE MYOCARDIAL INFARCTION APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 2 DAYS 16 DAYS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: PEPTIC ULCER, GALLSTONES, PARKINSON DISEASE							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 24, 1985 to OCTOBER 10, 1985 that (I) (we) last saw the deceased alive on OCTOBER 10, 1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Aurora C. Tan, M.D.				22c. DATE SIGNED 10-10-85		22d. PHYSICIAN'S NAME (TYPE OR PRINT) AURORA C. TAN, M.D.	
22e. ADDRESS VA MEDICAL CENTER, FORT HOWARD, MD				21052			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/14/1985		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest		23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills Maryland	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc.				25a. DATE REC'D BY REGISTRAR OCT 14 1985		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
7922 Wise Avenue Dundalk, Maryland 21222							

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove subpart pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 2 7 2 5 9
1- FOR STATE REGISTRAR		REG. NO.								
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR
FANNIE		GERSHBERG						OCT. 23, 85		3 A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female		Caucasion		12 TH 25 1898		87		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Russia		USA				Baltimore County		MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
RANDALLSTOWN		Baltimore County General Hosp.		Housewife		Home				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		
Md		Baltimore		Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>		3952 W. Northern Pkwy		21215
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS
Koinsberg				No		217-48-1844		Maurice A. Gershberg (son)		5701 Rubin Dr. Balt., Md 21215
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u></u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 7, 19 85</u> to <u>Oct. 23, 19 85</u> , that (I) (we) lost saw the deceased alive on <u>Oct. 23, 19 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not view the body after death.										
22b. SIGNATURE <u>Shoum Pourmotabbed, M.D.</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>								22c. DATE SIGNED 10-23-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GHASSEM POURMOTABBED						22e. ADDRESS Balt. Co. Gen. Hospital				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Removal		10-23-85								
24. FUNERAL DIRECTOR NAME STATE ANATOMY BOARD						ADDRESS BALTIMORE, MD.		25a. DATE REC'D. BY REGISTRAR OCT 24 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

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303096

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 2 6 0

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ADELE R. GIBMEYER			2a. DATE OF DEATH MONTH 10 DAY 25 YEAR 85 2b. HOUR 12 PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH 4 DAY 30 YEAR 1905		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE County MD.	
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST JOSEPH HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Maryland		13b. COUNTY Carroll	13c. CITY OR TOWN Manchester	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST George MIDDLE Burch LAST Swann		15. MOTHER'S MAIDEN NAME FIRST Jesse MIDDLE Swann LAST Swann		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-09-9072		17. INFORMANT Gloria Forrester - Same as #13c
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Ischemic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) years				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NO WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (1) (this hospital) attended the deceased from 10/6/85 to 10/25/85 , that (1) we lost 10/25/85 and that in my (our) opinion death occurred on the date and hour and from the cause as stated above. If we did not view the body after death.				
22b. SIGNATURE Mark S. Kaplan M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10/25/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK S. KAPLAN M.D.		22e. ADDRESS 16918 York Rd. Monkton		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE 10-28-85	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley	
23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville, Balto. Md.		25a. DATE REC'D. BY REGISTRAR OCT 28 1985		
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204		25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

289053

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) LOUIS August GILLAND			2a. DATE OF DEATH MONTH DAY YEAR 10 6 85		2b. HOUR 2:26 p.m.
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 3 - 2 - 1900		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10 CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) G.B.M.C.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter	12b. KIND OF BUSINESS OR INDUSTRY U.S. Army	
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 9414 Old Harford Rd. 21234
14 FATHER'S NAME FIRST MIDDLE LAST Thomas A. Gilland		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie E. Stedtler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-01-6563		17 INFORMANT ADDRESS Robert L. Gilland 600 W. Joppa Rd. 21204	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest 8990 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Renal Failure DUE TO, OR AS A CONSEQUENCE OF (c) Old myocardial infarction					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes Years Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a Cerebrovascular accident; Burns on leg and buttock					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Sept. 13, 1985 , to Oct. 6, 1985 , that (I) (we) last saw the deceased alive on Oct. 6, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Joel Hammer MD		DEGREE MD		22c. DATE SIGNED 10/7/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOEL L. HAMMER, M.D.		22e. ADDRESS 6701 N. CHARLES ST. BALT. MD. 21204			
23a. BURIAL, CREMATION, REMOVAL (SEE INSTRUCTIONS) Burial	23b. DATE 10-10-85	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Balto., Md.		
24 FUNERAL DIRECTOR NAME LASSAHL FUNERAL HOME		ADDRESS 740' BELAIR RD		25a. DATE REC'D. BY REGISTRAR 9 1985	25b. REGISTRAR'S SIGNATURE John Davidson

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MAILED
JUN 10 1964

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or letter containing several paragraphs of text.]

100-100000
100-100000
100-100000
100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

287055

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 2 6 2

1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Ruby Jean Gilleland				2a. DATE OF DEATH MONTH DAY YEAR October 03, 1985			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 09 26 1927		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD	
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3420 Loganview Dr. 21222		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Four Roses		12b. KIND OF BUSINESS OR INDUSTRY Distillery	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Raymond Buhrman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Minnick		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			
16b. SOCIAL SECURITY NO. 216-24-2944		17. INFORMANT ADDRESS 21222 Jimmy Gilleland 8253 Longpoint Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY FAILURE &</u> DUE TO, OR AS A CONSEQUENCE OF <u>LIVER FAILURE &</u> (b) <u>METASTATIC COLON CANCER</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE H.K. Holland M.D.				DEGREE M.D.		22c. DATE SIGNED 10/7/85	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) H.K. Holland M.D.				22c. ADDRESS Johns Hopkins Hospital Baltimore, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/5/85		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
24. FUNERAL DIRECTOR Connolly Funeral Home of Dundalk				25. DATE REC'D BY REGISTRAR OCT 9 1985			
				26. REGISTRAR'S SIGNATURE Julia Davidson			

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 2 6 3

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Jerome Martin Gilroy			2a. DATE OF DEATH MONTH DAY YEAR October 5 1985		2b. HOUR 5:47p M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 13, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Rossville 21237		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baggage Man		12b. KIND OF BUSINESS OR INDUSTRY Rail Road	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Gilroy		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora Malloy		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW11	
17. INFORMANT Mary C. Gilroy (wife)		18. ADDRESS (same)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (this hospital) attended the deceased from October 1, 19 85, to October 5, 19 85, that (we) lost saw the deceased alive on October 5, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.	
22b. SIGNATURE (Signature)		22c. DATE SIGNED 10-5-85		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Addie Hilda Grim, M.D.		22e. ADDRESS 9000 Franklin Square Drive 21237	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/09/85		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR Brazzinski Funeral Home PA 1407 Old Eastern Ave.		25a. DATE REC'D. BY REGISTRAR OCT 8 1985		25b. REGISTRAR'S SIGNATURE (Signature)		26. TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be retained by the hospital or attending physician.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Brain Cancer - GliomaAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHConditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 2 7 2 6 4
1. FOR STATE REGISTRAR										REG. NO.
1. DECEASED NAME (TYPE OR PRINT) Josephine S. Giuffrida					2a. DATE OF DEATH MONTH DAY YEAR 10-14-85		2b. HOUR 4²⁰ P M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 24, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stella Maris Hospice				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. CITY Baltimore		13c. CITY OR TOWN Parkville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2812 Lindwood Avenue 21234		
14. FATHER'S NAME FIRST MIDDLE LAST Louis Salafia				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline Bologna						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-017-081		17. INFORMANT ADDRESS Louis V. Salafia 1321 Register Ave. 21239						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) recent stroke DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 8/31 , 19 83 , to 10/14 , 19 85 , that (I) (we) last saw the deceased alive on 10/12 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Eddie Nakhuda				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-14-85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eddie Nakhuda				22e. ADDRESS 2300 Dulany Valley Rd. Towson 21204						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct 18 1985		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland				
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc. Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR OCT 15 1985		25b. REGISTRAR'S SIGNATURE Gina Davidson-Randall				

200000

Female

White

Oct. 2, 1904

80

1891

U.S.A.

x

Howeville

Cartledge

Baltimore

Lexington

x

2815 Lincoln Avenue 21214

Female

Female

Female

Female

10

270-01-001

Louis W. Bell 1921 No. 1st St. 2123

Female

Oct 15 1904

New Cambridge

Female

Female

Louise W. Bell, Inc. 1921 No. 1st St. 2123

289155

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Sister Clarabel Glynn				2a. DATE OF DEATH MONTH DAY YEAR October 10, 1985		2b. HOUR M AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Dec. 26, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 79	
7a. BIRTHPLACE (STATE OR FOREIGN) Ireland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Essex 21221		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1706 Old Eastern Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook		12b. KIND OF BUSINESS OR INDUSTRY Religious Order	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 1706 Old Eastern Ave. 21221		14. FATHER'S NAME FIRST MIDDLE LAST Michael Glynn		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Brigid Hyland		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -	
16b. SOCIAL SECURITY NO. 217 58 9496		17. INFORMANT Sr. Ellen Eugene		17b. ADDRESS 1706 Old Eastern Ave. Balto., Md. 21221		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR PM 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>9/26</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Patricia A Savadel		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-11-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICIA SAVADEL		22e. ADDRESS 7600 OSLER DRIVE TOWSON MD					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 10/14/85		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR Brazdzinski Funeral Home PA		25a. DATE REC'D. BY REGISTRAR 21221		25b. REGISTRAR'S SIGNATURE John Davidson-Randall		25c. DATE OCT 14 1985	

BP

October 10, 1952

Director, Cincinnati

Re: [illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]

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290066

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 2 6 6

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FRANCES E GOCKE			2a. DATE OF DEATH MONTH DAY YEAR 10 12 1985			2b. HOUR 12.50 PM			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 6, 1901		6 AGE (IN YEARS LAST BIRTHDAY) 84		7. IF UNDER 1 YEAR MONTHS DAYS YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD			
10 CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) GBMC 6701 N. CHARLES STREET				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 21 Linden Terrace 21204	
14 FATHER'S NAME FIRST MIDDLE LAST Ernest L. Love				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maple E. Baldwin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-74-1323		17 INFORMANT ADDRESS Mrs Patricia A. White, Same As #13e 21204					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE ORGAN FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (c) PERFORATED COLON								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO									
19a. DATE OF OPERATION 9/27/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED OBSTRUCTING CARCINOMA RECTO-SIGMOID				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (h) (this hospital) attended the deceased from 9/24 , 19 85 , to 10/12 , 19 85 , that (l) (we) lost saw the deceased alive on 10/12 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (h) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Uberoi				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10/12/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR KULDIP S. UBEROI				22e. ADDRESS GBMC 6701 N. CHARLES STREET, TOWSON MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-15-85		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville, Balto. Md.			
24 FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204				25a. DATE REC'D. BY REGISTRAR OCT 15 1985		25b. REGISTRAR'S SIGNATURE H. L. Baldwin-Randall			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Properly used, these should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

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SALTINE COUNTY

STATE OF INDIANA

IN



MULTIPLE ORGAN FAILURE

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PERFORATED COLON

DESTRUCTION OF COLONIC RECTO-SIGMOID

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STATE OF INDIANA, COUNTY OF SALTINE, TOWNSHIP OF

IN

290016

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 2 6 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Vernon G. Goeb			2a. DATE OF DEATH MONTH DAY YEAR October 10, 1985		2b. HOUR 2:30A M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 27, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 328 Dunkirk Road 21212		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auto Cleaner	12b. KIND OF BUSINESS OR INDUSTRY Automobile	
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Lawrence Lawrence Goeb		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Cecelia Burns			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII	17. INFORMANT ADDRESS Mrs. Mildred Comegys 328 Dunkirk Road 21212			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I: DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

acute CVA

DUE TO, OR AS A CONSEQUENCE OF

(b) Zener ASCVD

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>N. Carmona</i>	DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/11/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nestor M. Carmona		22e. ADDRESS 6012 Harford Road	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10-14-85	23c. NAME OF CEMETERY OR CREMATORY Garrison Forest V.A.	23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills Baltimore Maryland
24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home 6500 York Road 21212		25a. DATE REC'D. BY REGISTRAR OCT 15 1985	25b. REGISTRAR'S SIGNATURE <i>the Registrar</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be called at once.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILBUR FRANCIS GOETZ			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 10, 1985			2b. HOUR 3:05 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 16, 1926		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD	
10. CITY OR TOWN OF DEATH CATONSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1309 BIDDLE COURT		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESPERSON		12b. KIND OF BUSINESS OR INDUSTRY JAMES WALKER, INC.	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN CATONSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST CLARENCE P. GOETZ		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA M. NAGENGAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 220/12/9535	
17. INFORMANT SCOTT GOETZ		17a. ADDRESS 1309 BIDDLE COURT CATONSVILLE, MD 21228		17b. DATE OCTOBER 10, 1985		17c. SIGNATURE [Signature]	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA OF DUE TO, OR AS A CONSEQUENCE OF (b) UNCERTAIN PRIMARY DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)			
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. I certify that (1) this hospital attended the deceased from August 23, 1985, to October 10, 1985, that (1) we last saw the deceased alive on September 18, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) we (1) did (1) did not have the body after death.	
22a. SIGNATURE [Signature]		22b. DEGREE MD		22c. DATE SIGNED 10/11/85		22d. PHYSICIAN'S NAME (TYPE OR PRINT) DIANA H. GRIFFITHS	
22e. ADDRESS 900 CATON AVE BALT		22f. CITY OR TOWN BALTIMORE		22g. COUNTY BALTIMORE		22h. STATE MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCTOBER 12, 1985		23c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD	
24. FUNERAL DIRECTOR NAME SLACK FUNERAL HOME		24a. ADDRESS ELLICOTT CITY, MD 21043		24b. DATE RECEIVED BY REGISTRAR OCT 15 1985		24c. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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WILKINSON JIMMY

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Handwritten notes and stamps, including a large '3' and some illegible markings.

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WILKINSON JIMMY

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Extensive handwritten notes and stamps at the bottom of the page, including a large '3' and various illegible markings.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 2 6 9

1- FOR
STATE
REGISTRAR

REG. NO.

311045

1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
JOSEPH		GOLDSTEIN		THURS. OCT. 31, 1985		4:30 PM	
3 SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
MALE	WHITE	MAR. 15, 1889		96		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
POLAND	USA			BALTIMORE COUNTY MD.			
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
PIKESVILLE	JEWISH CONVAL. & NURSING HOME		CARPENTER		BUILDING		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE	13b. CITY OR TOWN	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE			
MARYLAND	BALTIMORE	PIKESVILLE		7920 SCOTTS LEVEL RD. (21208)			
14 FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
UNKNOWN UNKNOWN		UNKNOWN UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS			
NO		062-09-6858		BENJ. GOLDSTEIN 8226 DRY CREEK DR. TAMPA, FLORIDA.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic heart disease

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4 yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/1</u> , 19 <u>74</u> , to <u>10/31</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>10/19</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>H. Friedman</u> DEGREE <u>MD</u>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11/1/85</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>H. Ronald Friedman</u>		22e. ADDRESS <u>6715 PARK HEIGHTS AVE. BALTO., MD. (21215)</u>	

23a. BURIAL, CREMATION, REMOVAL (SEE INSTRUCTIONS)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	11/3/85	BETH EL MEM. PARK	PARAMUS, N.J.
24. FUNERAL DIRECTOR'S NAME <u>SOL LEVINSON & BROS.</u>		25a. DATE OF REGISTRATION <u>NOV 05 1985</u>	
24. FUNERAL DIRECTOR'S ADDRESS <u>6010 REISTERSTOWN RD. BALTIMORE., MD. (21215)</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be promptly filled in by the funeral director. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

31102



309053

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)				20. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Anna Lombardi GRABOWSKI				October 31, 1985								9:55AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		Caucasian		Apr. 30, 1921		64 YRS.		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA				Baltimore County				MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Franklin Square Hospital						Inspector		Western Elec.			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland				Baltimore		Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7400 Meadowbranch Ct, 21237			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
unknown				unknown									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS							
No		--		219-05-4086		John J. Grabowski		Joppatown, Md. 21085 258 Foster Knoll Dr					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest													
DUE TO, OR AS A CONSEQUENCE OF (b) Bronchopneumonia													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF (c) Squamous cell carcinoma with metastasis													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. T9				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from Oct. 25, 19 85, to Oct. 31, 19 85, that (we) last saw the deceased alive on Oct. 31, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Ralph Woodward								DEGREE		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ralph Woodward								ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		10-31-85			
22e. ADDRESS 9000 Franklin Square Dr., 21237													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial				11/4/85		Holy Redeemer Cem		Balto, Md.					
24. FUNERAL DIRECTOR NAME				3331 Brehms Lane				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
SCHIMUNEK FUNERAL HOME, Balto, Md. 21218								NOV 01 1985					

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294007

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 85 27271							
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH			2b. HOUR	
FIRST MIDDLE LAST Vonz Wilson GRAYBEAL					MONTH DAY YEAR October 16, 1985			12:40a M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		Cau.		MONTH DAY YEAR 3 19 22		63 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
North Carolina		U.S.A.				Baltimore County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Balto.		Franklin Square Hosp.				Silversmith		Kirk-Stief	
13a. STATE					13b. CITY OR TOWN		13c. STREET ADDRESS / ZIP CODE		
Md.					Balto.		5617 Mayview Ave. 21206		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST John Graybeal					FIRST MIDDLE LAST Cora Shoemaker				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
Yes					W.W.II		235-26-1918 Helen M. Graybeal 5617 Mayview Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Cardiogenic Shock</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Acute Renal Failure</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. certify that (I) (this hospital) attended the deceased from <u>October 14, 1985</u> to <u>October 16, 1985</u> , that (I) (we) last saw the deceased alive on <u>October 16, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.									
22b. SIGNATURE						DEGREE		22c. DATE SIGNED	
<u>P. Barrenechea, M.D.</u>						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		10/16/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			
P. Barrenechea, M.D.						9000 Franklin Sq. DR., 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial			10-18-85		Parkwood Cem.		City or Town County State Balto. Md.		
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS John C. Miller Inc. 6415 Belair Rd.						OCT 17 1985		<u>G. Miller</u>	



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 2 7 2

FOR
1- STATE
REGISTRAR

REG. NO.

304042

1. DECEASED NAME (TYPE OR PRINT) Carl Hamilton Greene			2a. DATE OF DEATH MONTH DAY YEAR October 27, 1985		2b. HOUR 3:15 AM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Feb. 1, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Randallstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Meat Packing
13a. STATE Maryland			13b. CITY OR TOWN Baltimore	13c. STREET ADDRESS / ZIP CODE Apt. 416 4206 Loch Raven Blvd. 21218	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Greene		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl Ryan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No N/A		16b. SOCIAL SECURITY NO. 215-09-9710		17. INFORMANT ADDRESS 21 Benway Court Rodney C. Greene Catonsville, MD 21228	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>respiratory insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>untreated recurrent resp. infection</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>advanced cerebral degeneration</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 9</u> , 19 <u>88</u> , to <u>10/27</u> , 19 <u>88</u> , that (I) (we) lost saw the deceased alive on <u>Sept</u> , 19 <u>88</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Marcelino D. Albuerne</u>		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/29/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marcelino D. Albuerne, M.D.		22e. ADDRESS 5772 Westview Mall Balto., MD 21228			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/30/85		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland					
24. FUNERAL DIRECTOR NAME MacNabb Funeral Home		ADDRESS Catonsville, MD		25a. DATE REC'D. BY REGISTRAR OCT 29 1985	
25b. REGISTRAR'S SIGNATURE					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

201013



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 2 7 2 7 3	
FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Mertice E. Greenple			2a. DATE OF DEATH MONTH DAY YEAR 10 04 85			2b. HOUR 8 15 A M					
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 01 21 02		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY, MD.					
10. CITY OR TOWN OF DEATH 21234		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VALLEY VIEW NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MEDICAL LIBRARIAN			12b. KIND OF BUSINESS OR INDUSTRY HOSPITAL		
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN LUTHERVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1201 PURDY COURT 21093			
14. FATHER'S NAME FIRST MIDDLE LAST JAMES G. TALBOT				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JULIA HANCOCK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-10-0847		17. INFORMANT ADDRESS HARRIET E. ANDREWS LUTHERVILLE, MD 21093							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) overwhelming bacterial infection DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Parkinson's disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 5 year											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/5 68 to oct 4 85 , that (I) (we) last saw the deceased alive on oct 3 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Samuel O'Mansky				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED oct 4 85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAMUEL O'MANSKY				22e. ADDRESS 8405A LOCH RAVEN BLVD							
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) CREMATION		23b. DATE OCT. 8, '85		23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CEMETERY				23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON				ADDRESS 8521 LOCH RAVEN BLVD.				25a. DATE REC'D. BY REGISTRAR OCT 7 1985			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 2 7 4

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRIEDA M. GREUL			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 20, 1985		2b. HOUR 6:15P_M				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MARCH 18, 1911		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 74 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY, MD.			
10. CITY OR TOWN OF DEATH 21234		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2113-F TOWNHILL ROAD			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY		12b. KIND OF BUSINESS OR INDUSTRY LEGAL		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN 21234		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST JOHN D. SPANGLER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE BAKER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 214-01-0840		17. INFORMANT ADDRESS MARY ANN VAN DRIEL NEW MILFORD, CONN. 06776				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>subacute bacterial meningitis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 yrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>85</u> , to <u>Oct</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>8/11</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Arthur Serpic</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED <u>10/21/85</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR SERPIC, M.D.					22e. ADDRESS ST. JOSEPH HOSPITAL 337-1000				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE OCT. 24, '85		23c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE COUNTY, MARYLAND		
24. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON					25a. DATE REC'D. BY REGISTRAR OCT 22 1985		25b. REGISTRAR'S SIGNATURE <u>John H. Mason</u>		
ADDRESS 8521 LOCH RAVEN BLVD.									

MEDICAL CERTIFICATION

1000

20% COLDEN FIBER

WELLMAN FIBER



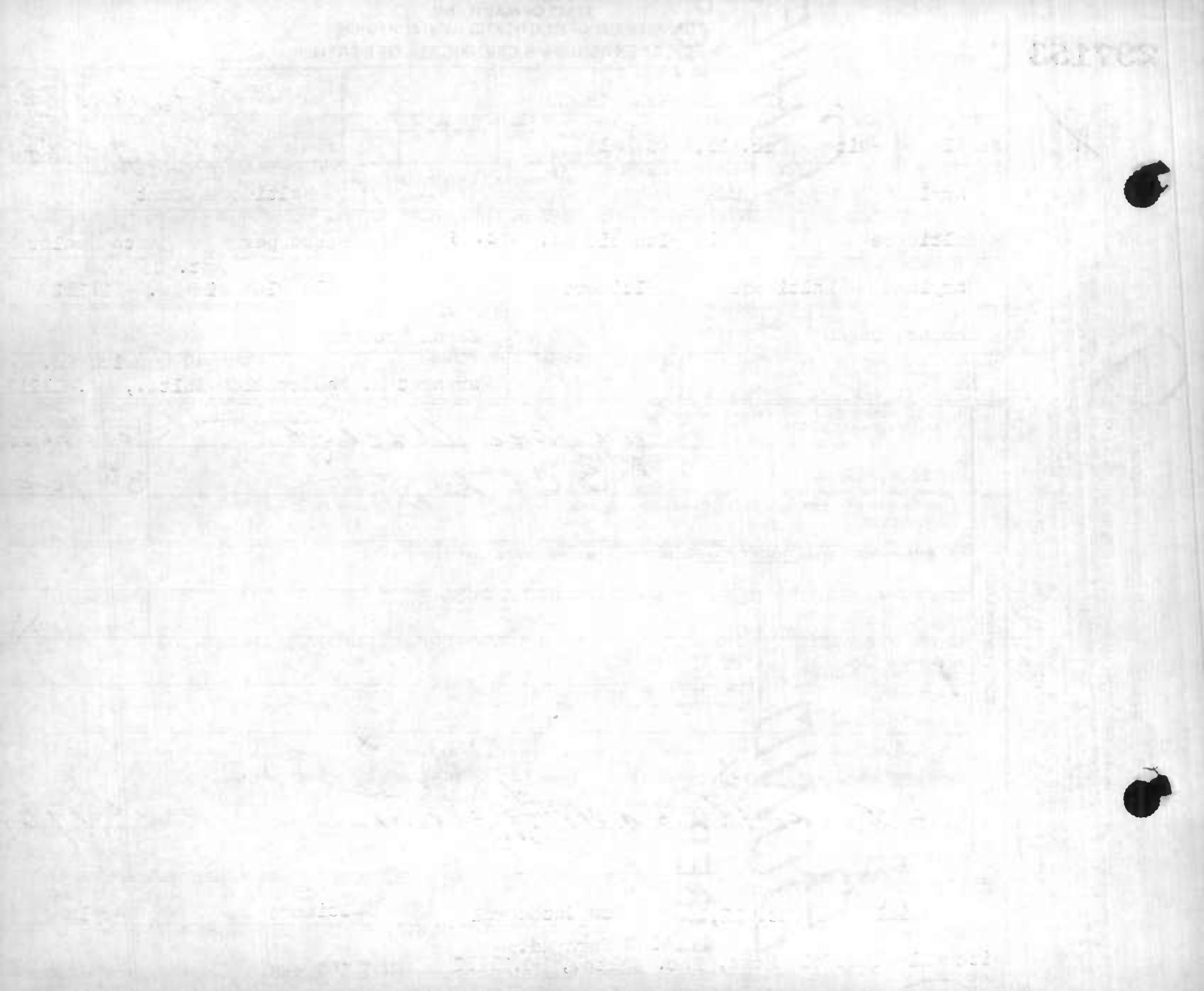
297153

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. (OVER PAGE 5). 2. AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M 7/76

Filing G609 item 16b										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										5 27275																																																											
1- FOR STATE REGISTRAR 11/14/85 rja										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.																																																											
1. DECEASED NAME (TYPE OR PRINT)										FIRST MIDDLE LAST										2a. DATE KNOWN OF DEATH										MONTH DAY YEAR										2b. HOUR																																							
CATHERINE THERESA GROGAN																				October 19, 1985										8:57 AM																																																	
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (IN YEARS)										IF UNDER 1 YR.										IF UNDER 24 HRS.										7c. DATE PRONOUNCED DEAD										2d. HOUR									
Female										White										Dec. 23, 1903										81										MONTHS DAYS										HOURS MIN										October 19, 1985										8:57 AM									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH																																																	
Maryland										USA																				Baltimore County										MD.																																							
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b. KIND OF BUSINESS OR INDUSTRY																																																	
Baltimore										6814 Blenheim Rd. Apt. C										Bookkeeper										Auto Dealer																																																	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET ADDRESS										Apt. C																			
										Maryland										Baltimore										Baltimore										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										6814 Blenheim Rd.										21212																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																																					
FIRST MIDDLE LAST										FIRST MIDDLE LAST																																																																					
Thomas Grogan										Sarah Brannan																																																																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO, OR UNKNOWN)										16b. SOCIAL SECURITY NO.										17. INFORMANT										ADDRESS										40 Dunkirk Rd.																																							
No										213-01-3998										Margaret M. Bauersfeld										Balto., Md.										21212																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART I DEATH WAS CAUSED BY:										IMMEDIATE CAUSE (a)										DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
																				Cardiac Arrest										ASCD										Sudden																																							
																				(b)										DUE TO, OR AS A CONSEQUENCE OF										3+ yrs																																							
																				(c)																																																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c).																																																																															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN REAR OF PART 1 OR PART 2)																																																											
										HOUR A.M. MONTH DAY YEAR																																																																					
21d. INJURY OCCURRED										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION										CITY OR TOWN										COUNTY										STATE																													
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>																				STREET																																																											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:										Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																																																					
ACTUAL SIGNATURE										TITLE (SPECIFY)										MEDICAL EXAMINER										DATE SIGNED										10/19/85																																							
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																																																																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION										CITY OR TOWN										COUNTY										STATE																			
Burial										Oct. 22, 1985										New Cathedral										Baltimore																				Maryland																													
24. FUNERAL DIRECTOR										NAME										ADDRESS										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																							
Mitchell-Wiedefeld Home, Inc.										6500 York Rd.																																																																					
										Balto., Md.										21212										OCT 22 1985																																																	



302005

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5

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1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Bertha V. Groszkowski</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>10 - 20 - 85</i>			2b. HOUR <i>5:51 AM</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>October 8, 1906</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>79</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Poland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Valley Nursing & Convalescent Center</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Javarr Owner</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD.</i>			13b. CITY OR TOWN <i>Balto.</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <i>3015 Pulaski Hwy 21224</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Wasilewski</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Frances Kalinowski</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>212-10-6794D</i>		17. INFORMANT ADDRESS <i>Jean Orozco 5510 Todd Ave. 21206</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Hepatic Encephalopathy</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (we) attended the deceased from <i>June 85</i> to <i>10-20</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>10-17</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <i>M. Kowalewski</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>10-22-85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>8604 Highland M. Kowalewski</i>				22e. ADDRESS <i>M. Kowalewski</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>10-24-1985</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Rosary Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. Md.</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>John M. Weber & Sons Inc. 401 S. Chester St.</i>				25a. DATE REC'D. BY REGISTRAR <i>OCT 25 1985</i>		25b. REGISTRAR'S SIGNATURE <i>John M. Weber</i>			

BP



281052

Item #15 10/8/85 mth F#608

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carolyn I. Grubbs			2a. DATE OF DEATH MONTH DAY YEAR October 3, 1985		2b. HOUR 8:36 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 20, 1947		6. AGE (IN YEARS LAST BIRTHDAY) 37	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Middle River	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 21220 22 Beach Drive Apt. B1		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress	12b. KIND OF BUSINESS OR INDUSTRY Restaurant	
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Middle River	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 22 Beach Dr. Apt. B1 21220	
14. FATHER'S NAME FIRST MIDDLE LAST Dewey Persinger			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bonnie Mc Daniel		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -	17. INFORMANT ADDRESS Lawrence Grubbs, Husband Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Colon Cancer DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR (A.M. OR P.M.) MONTH DAY YEAR 8:36 P.M. 10 3 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) this hospital attended the deceased from JUNE 25 1985 to OCT 03 1985 that (I) (we) last saw the deceased alive on JUNE 25 1985 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ronald Attanasio		DEGREE MD		22c. DATE SIGNED 10/3/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RONALD ATTANASIO		22e. ADDRESS 1012 OLD NORTH PT. Rd. BALT. MD.			
23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE 10/5/85	23c. NAME OF CEMETERY OR CREMATORY Holly Hill Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.	
24. FUNERAL DIRECTOR Brodzinski Funeral Home PA 1407 Old Eastern Ave		25a. DATE REC'D. BY REGISTRAR OCT 4 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendell	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate from this form and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause of death, the medical examiner must be notified at once.

288129

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Rachel A. Gruber			2a. DATE OF DEATH MONTH DAY YEAR October 4, 1985		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 6 1890		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Edgemere	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3117 Whiteway Road 21219		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Own Home		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Edgemere
14. FATHER'S NAME FIRST MIDDLE LAST Abraham L. Shearer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Scheaffer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 213-07-8977		17. INFORMANT ADDRESS Elizabeth G. Colvin 3117 Whiteway Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic C.V. Dis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 1945 to Oct 4, 1985 that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R. G. Windsor		DEGREE M.D.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROGER G WINDSOR		22e. ADDRESS 1012 Old No Point Rd. Balt., Md. 21224			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/8/85		23c. NAME OF CEMETERY OR CREMATORY Baltimore National	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, MD		24. FUNERAL DIRECTOR NAME ADDRESS Duda-Ruck Funeral Home of Dundalk, Inc.			
24. FUNERAL DIRECTOR NAME ADDRESS Duda-Ruck Funeral Home of Dundalk, Inc.		OCT 10 1985 Julia Davidson-Randall			

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be certified at once.



291017

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William GUDGEON			2a. DATE OF DEATH MONTH DAY YEAR October 10, 1985			2b. HOUR 3:10 a.m.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 27 1920		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired American Can Co.		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 307 N. Marlyn Ave. 21221	
14. FATHER'S NAME FIRST MIDDLE LAST Howard Gudgeon			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Ellinghouse							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 216-10-6958			17. INFORMANT ADDRESS Irma Gudgeon 307 N. Marlyn Ave. 21221				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Severe Hemorrhage Bilateral Pneumonia									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Complicated by Congestive Heart Failure (c) Rheumatic Heart Disease and also Complicated by Renal Insufficiency										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (this hospital) attended the deceased from 9-19 , 19 85 , to 10-10 , 19 85 , that (we) last saw the deceased alive on 10-10 , 19 85 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (do) (not) view the body after death.										
22b. SIGNATURE Cynthia C. Powers						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Cynthia C. Powers, M.D.						22e. ADDRESS 9000 Franklin Square Drive 21237				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/14/85		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Connelly Funeral Home 300 Mace Ave. 21221						25a. DATE REC'D. BY REGISTRAR OCT 16 1985		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

MEDICAL CERTIFICATION

TO HOSPITAL or ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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WINDMILL



281053

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN B GUERNSEY			2a. DATE OF DEATH MONTH DAY YEAR 10 02 85			2b. HOUR 3:30PM			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 10-02 29		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST JOSEPH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) VICE PRESIDENT		12b. KIND OF BUSINESS OR INDUSTRY STEEL	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST BERTRAND GUERNSEY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RUTH WHITEHEAD			16. STREET ADDRESS / ZIP CODE 1314 BRIXTON ROAD 21239			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 284-26-0440		17. INFORMANT ADDRESS BETTY GUERNSEY 1314 BRIXTON RD. 21239				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell Ca. of Lung. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (a) this hospital attended the deceased from Sept 26 19 85 to Oct 2 19 85 , that (b) we lost sight of the body on Oct 2 19 85 and that in my opinion death occurred on the date and hour and from the causes stated above.									
22a. SIGNATURE Marc I. Leavey MD			22b. ADDRESS 7600 Osler Drive #315, Towson 21204			22c. DATE SIGNED 20 Oct 85			
23a. BURIAL, CREMATION, REMOVAL (TYPE) BURIAL			23b. DATE OCT. 7, '85			23c. NAME OF CEMETERY OR CREMATORY MORELAND MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE COUNTY, MD	
24. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON 8521 LOCH RAVEN BLVD.						25a. DATE REC'D. BY REGISTRAR OCT 4 1985		25b. REGISTRAR'S SIGNATURE John Davidson	

MEDICAL CERTIFICATION

7
9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified of the death.

BP

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GUESSEY

DOWN

CANASTA

MALE

10-02-20

BALTIMORE COUNTY

X

ST JOSEPH HOSPITAL

TOWSON

BALTIMORE

X

171 BRINTON ROAD



Person cell in building

Handwritten notes and markings, including a large 'X' and various scribbles.

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Food Order was 2301 Town and

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304047

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 2 8 1

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William - Gumpman			2a. DATE OF DEATH MONTH DAY YEAR October 28, 1985			2b. HOUR M 10				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 30, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Balto. G. & E. Meter Reader		12b. KIND OF BUSINESS OR Customer Service		
13a. STATE Md.			13b. COUNTY Baltimore		13c. CITY OR TOWN Parkville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2909 Alden Road 21234	
14. FATHER'S NAME FIRST MIDDLE LAST George - Gumpman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth - Armbrust							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 1		17. INFORMANT ADDRESS Mr. Charles W. Springer 2612 Wycliff Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) ASCD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) 5 cm infarct APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 25 yr 25+ yr										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Dec 10 19 85 to Oct 28 19 85 , that (I) (we) last saw the deceased alive on Oct 10 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE S. Elliott Harris MD			DEGREE MD.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/29/85		
22d. PHYSICIAN'S NAME (IF OTHER)			22e. ADDRESS 8100 Harford Rd. Baltimore, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 30, 1985		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc. Baltimore, Maryland					25a. RECEIVED BY REGISTRAR OCT 29 1985		25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates on pages 1 and 2 and attach them to the funeral director's copy with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Officer's Name: _____

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Figure 1

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Document 2821, OF. 13

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8-5

27282

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WINIFRED MARTIN GUNDRY			2a. DATE OF DEATH MONTH DAY YEAR October 20, 1985		2b. HOUR 9:09 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 14, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Ruxton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11 Ruxview Ct., Apt. 102		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Balto.	13c. CITY OR TOWN Ruxton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Patrick F. Martin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Corcoran			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216 05 5524		17. INFORMANT ADDRESS Dr. Louis P. Gundry, Same	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CEREBRAL INFARCT</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>PITUITARY ADENOMA</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/26/85</u> to <u>10/20/85</u> , that (I) (we) lost <u>10/6</u> saw the deceased alive on <u>10/6</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If was (saw) (did not see) the body after death)					
22b. SIGNATURE <u>Alberto J. Diaz</u>		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>10/21/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Alberto J. Diaz, MD		22e. ADDRESS 7600 Osler Drive., Balto., MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/24/85	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, MD	
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. ADDRESS 4905 York Road Balto., MD 21212			25a. DATE REC'D. BY REGISTRAR OCT 22 1985		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>

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301058

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 2 8 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOSEPH GUZZO			2a. DATE OF DEATH MONTH DAY YEAR 10 23 '85		2b. HOUR 400AM
3. SEX MALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR November 10, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Sicily	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) GBMC-6701 N. CHARLES ST.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self employed		12b. KIND OF BUSINESS OR INDUSTRY Builder
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. CITY OR TOWN Baltimore	13c. CITY OR TOWN Towson	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Paul Guzzo		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Constance Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-22-2705	17. INFORMANT ADDRESS Helen M. Good- 7322 Yorktowne Dr. 21204			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC OBSTRUCTIVE PULMONARY DISEASE					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: END STAGE RENAL DISEASE, SEVERE ANEMIA, GASTROINTESTINAL BLEED					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9-17 1985	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE GBMC-6701 N. CHARLES ST. Parkville Balto. Md.			
22a. I certify that (I) (this hospital) attended the deceased from 9-17 1985 , to 10-23 1985 , that (I) (we) lost saw the deceased alive on 10-23 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Jay Z. Howard		DEGREE MD		22c. DATE SIGNED 10-23-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAY HOWARD, M.D.		22e. ADDRESS GBMC-6701 N. CHARLES ST.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10-25-85	23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville Balto. Md.	
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.		ADDRESS 1050 York Rd. Towson, Md. 21204		25a. DATE RECEIVED BY REGISTRAR OCT 24 1985	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

MEDICAL CERTIFICATION

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9

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon copy and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

301058

STANDARD

WISCONSIN

BALTIMORE COUNTY

ST. CHARLES ST.

WISCONSIN

RESISTANCE

PERMANENT

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

END STATE FATAL DISEASE, SEVERE ASBESTOS PNEUMONITIS, LUNG

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ST. CHARLES ST.

WISCONSIN

290130

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5

2 7 2 8 4

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN HAFNER			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 14, 1985			2b. HOUR 12:30 AM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 3/19/ 1894		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH ARBUTUS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH A CITY, GIVE STREET ADDRESS) 5510 CARVILLE AVENUE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Boilermaker		12b. KIND OF BUSINESS OR INDUSTRY B & O railroad	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN ARBUTUS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST George Hafner			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Schlicker			13e. STREET ADDRESS / ZIP CODE 5510 CARVILLE AVENUE 21227			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) n/a			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) n/a		17. INFORMANT ADDRESS Mr. John Hafner 5510 Carville Avenue				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Lung - Bilob</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 mo.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Arteriosclerotic heart disease</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>Feb 2</u> , 19 <u>67</u> to <u>Oct 14</u> , 19 <u>85</u> , that (I) <u>(was)</u> lost saw the deceased alive on <u>Oct 13</u> , 19 <u>85</u> , and that in (my) <u>(own)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(did)</u> <u>(did not)</u> view the body after death.									
22b. SIGNATURE <u>A. Bradley Daugharthy M.D.</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 14 Oct 85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. A. Bradley Daugharthy, M.D.			22e. ADDRESS 1264 Francis Avenue 21227						
23a. BURIAL, CREMATION, REMOVAL SPECIAL Burial			23b. DATE 10/17/85		23c. NAME OF CEMETERY OR CREMATORY Western Cemetery		23d. LOCATION BALTIMORE CITY, MARYLAND Baltimore City, Maryland		
24. FUNERAL DIRECTOR NAME Ambrose, Inc.			ADDRESS 1328 Sulphur Spring Road 21227			25a. DATE REC'D BY REGISTRAR OCT 15 1985			

BP

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291021

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 2 8 5

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Catherine V. Hagan			2a. DATE OF DEATH MONTH DAY YEAR October 12, 1985		2b. HOUR M 8:00Am	
3 SEX Female		4. RACE White		5 DATE OF BIRTH MONTH DAY YEAR Nov. 21 1905		
6 AGE (IN YEARS (LAST BIRTHDAY)) 79		IF UNDER 1 YEAR MONTHS DAYS YRS.		IF UNDER 24 HRS. HOURS MIN. MD.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County						
10 CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired National Tube Co.		
12b KIND OF BUSINESS OR INDUSTRY		13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13b. STREET ADDRESS / ZIP CODE 1306 First Road 21220		
14 FATHER'S NAME FIRST MIDDLE LAST John Hansberry		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora Hansberry				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. 162-03-1606		17 INFORMANT ADDRESS John Hagan 1306 First Road 21221		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Hypercarbia DUE TO, OR AS A CONSEQUENCE OF (c) Chronic obstructive pulmonary disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from September 9, 1985 , to October 12, 1985 , that (I) (we) lost saw the deceased alive on October 12, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
27b. SIGNATURE K. Kitchen MD		DEGREE MD		27c. DATE SIGNED 10-12-85		
27d. PHYSICIAN'S NAME (TYPE OR PRINT) Kay Kitchen MD		27e. ADDRESS 9000 Franklin Square Drive 21237				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 10/16/85		23c. NAME OF CEMETERY OR CREMATORY Holy Sepulchre		
23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham Mont. Pa.		25a. DATE REC'D. BY REGISTRAR Oct 16 1985				
24 FUNERAL DIRECTOR NAME ADDRESS Connolly Funeral Home 300 Mace Ave. 21221		25b. REGISTRAR'S SIGNATURE John Davidson-Randall				

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

130105



WALKER
BOND

SCOTCH
COTTON FIBRE

10-15-82

282061

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gerald George HAGAN			2a DATE OF DEATH MONTH DAY YEAR October 5, 1985		2b HOUR 10:10 P_M
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR June 5, 1925	6 AGE (IN YEARS LAST BIRTHDAY) 60 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 60	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10 CITY OR TOWN OF DEATH Rossville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanical Engineer		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Rosedale	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST John Hagan		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Celestine Schroll			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II Army 219-18-5611		17 INFORMANT ADDRESS Ruth E. Hagan 6804 Averill Rd. Apt. 1B	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left upper lobe lung abscess DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myelogenous Leukemia DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 2, 1985 to October 5, 1985 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 5, 1985 and that in <input checked="" type="checkbox"/> (my) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.					
22b. SIGNATURE Roger Moushabek		DEGREE M.D.		22c. DATE SIGNED 10/5/1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roger Moushabek, MD		22e. ADDRESS 9000 Franklin Square Dr., 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Oct 9 1985	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		
24 FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.			25a. DATE RECEIVED BY REGISTRY OCT 7 1985		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be filed with the death certificate.

1303061

DATE

TIME

DATE

TO

ATTENTION

U.S.A.

X

ADDRESS

Franklin D. Roosevelt Library

Washington, D.C.

REMARKS

REMARKS

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REMARKS

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IN II 1955-1956

IN II 1955-1956



Baltimore, Maryland

Oct 1955 - Oct 1956

Period

Leahurst J. Moore, Inc., Baltimore, Maryland

297107

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 2 7 2 8 7
CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR	
FRANK E. HAMMAKER		October 18, 1985	
3 SEX		4 RACE	
Male		White	
5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)	
Sept. 22, 1901		84 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
Maryland		U.S.A.	
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
		Baltimore County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
Towson		G.B.M.C.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Self employed		Monument Co.	
13a. STATE		13b. COUNTY	
Maryland		Baltimore	
13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Towson		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
Benjamin Frank Hammaker		Barbara Ensor	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
No		215-32-3123	
17 INFORMANT ADDRESS		17 INFORMANT ADDRESS	
Aileene C. Hammaker - same as #13e			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Pneumonia</u>		<u>1 week</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Vascular Accident</u>		<u>1 mo</u>	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterial Sclerosis - gave rise to</u>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	
		P.M. 19	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>6/9/57</u> to <u>10/18/85</u> , that (I) (we) last saw the deceased alive on <u>10/18/85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE		DEGREE	
<u>Franklin E. Leslie</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)	
<u>10/18/85</u>		Franklin E. Leslie, M.D.	
22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	
3501 St. Paul St., Balto., Md. 21218		Cremation	
23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
10-21-85		Westview	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR	
Balto. Md.		OCT 22 1985	
24 FUNERAL DIRECTOR NAME ADDRESS		25a. REGISTRAR'S SIGNATURE	
Ruck Towson Funeral Home, Inc. Towson, Md. 21204		<u>Sonia Gordon-Parker</u>	

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate from pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 2 7 2 8 8
CERTIFICATE OF DEATH

REG. NO.

309008

1. DECEASED NAME (Type or Print) ROSALIE Catherine HAMMERBACHER		2a. DATE OF DEATH MONTH DAY YEAR 10 30 85		2b. HOUR MIN. 8:10 A	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan 24, 1922	
6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If NOT IN SUCH FACILITY, GIVE STREET ADDRESS) STELLA MARIS HOSPICE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker	
12b. KIND OF BUSINESS OR INDUSTRY -----		13a. USUAL RESIDENCE (If NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Overlea			
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Baltimore, Md. 6903 Linden Avenue 21206			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Bonomo		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carmela Polgardo			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-56-7128		17. INFORMANT ADDRESS Baltimore, Md. George Hammerbacher 6903 Linden Ave 21206	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CANCER TO BONE - LIVER & BRAIN DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I to					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10-7-85 to 10-30-85 , that (I) (we) last saw the deceased alive on 10-30-85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did, did not, view the body after death.					
22b. SIGNATURE Kendall Falkner M.D.		DEGREE M.D.		22c. DATE SIGNED 10.30.85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KENDALL FALKNER - M.D.		22e. ADDRESS Stella Maris Hospice 2300 Dulaney Valley Rd. - Towson, MD 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov 2, 85		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.		24. FUNERAL DIRECTOR NAME The Dippel Funeral Homes, Inc 7110 Belair Rd. Baltimore, Md. 21206			
25a. DATE REC'D. BY REGISTRAR NOV 01 1985		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

204806

290049

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FRANK			2a. DATE OF DEATH MONTH DAY YEAR October 11, 1985			2b. HOUR 11:03 PM			
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 2 21 42		6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS.		7. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Baltimore Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	

13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1213 Cochran Ave. 21239	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Hampton				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Pitchford					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				16b. SOCIAL SECURITY NO. A 213-36-7457		17. INFORMANT ADDRESS Elizabeth Hampton 1213 Cochran Ave. 21239			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple intraabdominal abscesses		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) Chronic peritonitis	
DUE TO, OR AS A CONSEQUENCE OF		(c)	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a

Chronic hepatitis with cirrhosis; chronic renal failure

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/10 , 19 85 , to 10/11 , 19 85 , that (I) (we) last saw the deceased alive on 10/11 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Robert A. Palermo</i> map				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/12/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert A. Palermo, M.D.				22e. ADDRESS 6701 N. Charles St. Balto MD 21204			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10-17-85		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		23d. LOCATION (CITY OR TOWN) COUNTY STATE Anne Arundal Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS W.C.MARCH F/H CO. 1101 E. NORTH AVE.				25a. DATE REC'D. BY REGISTRAR OCT 15 1985		25b. REGISTRAR'S SIGNATURE <i>W. C. March</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified immediately.

Area 1, 1971-1972
 1971-1972

389089

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) THOMAS L. HANLON			2a. DATE OF DEATH MONTH DAY YEAR 10 5 1985		2b. HOUR 9:00 PM
3. SEX MALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 4 7 1915	6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	8b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.		
10 CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER BALTIMORE MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EXAMINER	12b. KIND OF BUSINESS OR INDUSTRY BALTO. CITY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN D. HANLON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTHA LANCASTER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 09 2541	17. INFORMANT ADDRESS FAMILY RECORDS			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) METASTATIC THROAT CA (SQUAMOUS CELL)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

b) MULTISYSTEM FAILURE

DUE TO, OR AS A CONSEQUENCE OF

c) CARDIAC ARREST

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (X) (hospital) attended the deceased from OCTOBER 1 19 85 to OCTOBER 5 19 85, that (1) (X) (lost saw the deceased alive on OCTOBER 5 19 85, and that in (my) (X) (my) opinion death occurred on the date and hour and from the causes stated above, (1) (X) (did) (X) (not) view the body after death			
22b. SIGNATURE M. El Defraul MD	DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED OCTOBER 5, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. EL DEFRAUL MD	22e. ADDRESS GBMC 6701 N. CHARLES STREET, TOWSON, MD 21204		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 10-9-1985	23c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S LONG GR.	23d. LOCATION CITY OR TOWN COUNTY STATE HYDRES BALTO. MARYLAND
24. FUNERAL DIRECTOR NAME EVANS CHAPLOF OF MEMORIES		ADDRESS 8800 ROAD HARFORD	25a. DATE REC'D. BY REGISTRAR OCT 14 1985
		25b. REGISTRAR'S SIGNATURE Greta Davidson-Henderson	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, immediate notification of the notified coroner is required.

000000

DATE: 10 15 1964

STATE OF CALIFORNIA

GENERAL INVESTIGATIVE DIVISION

LABORATORY OF FORENSIC MEDICINE

ANTHROPOLOGY SECTION

CRIMINAL INVESTIGATION

OCTOBER 15 1964

OCTOBER 15 1964

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OCTOBER 15 1964

DR. C. A. H. GALT, JR., M.D.

DR. C. A. H. GALT, JR., M.D.

OCT 14 1964

295046

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR XC 28534482

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN J HANN			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 12, 1985		2b HOUR 4:35 A M		
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 07 25 1924		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 61	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10 CITY OR TOWN OF DEATH FORT HOWARD		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) V.A.M.C. FORT HOWARD, MARYLAND		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assembly Line Worker- G.M.		12b KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND				13b COUNTY BALTIMORE		13c CITY OR TOWN Edgemere	
14 FATHER'S NAME FIRST MIDDLE LAST EARL V. HANN				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH DOERER			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17 INFORMANT ADDRESS CLINICAL RECORD, VAMC, FORT HOWARD, MARYLAND			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIOPULMONARY ARREST**

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF
b) **CIRRHOSIS, HYPOGLYCAEMIA**

DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

ASCENDING CHOLANGITIS

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from OCTOBER 7, 1985 to OCTOBER 12, 1985 , that (we) last saw the deceased alive on OCTOBER 12, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <i>Purushottan Mitra</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 10/12/85	
22d PHYSICIAN'S NAME (TYPE OR PRINT) PURUSHOTTAN MITRA, M.D.				22e ADDRESS V.A.M.C., FORT HOWARD, MARYLAND 21052			

MEDICAL CERTIFICATION

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/15/1985		23c NAME OF CEMETERY OR CREMATORY Gardens Of Faith		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24 FUNERAL DIRECTOR NAME Duda-Ruck, Inc.				ADDRESS 7922 Wise Avenue Dundalk, Maryland 21222		25a DATE REC'D. BY REGISTRAR OCT 18 1985	
						25b REGISTRAR'S SIGNATURE <i>Lelia Davidson-Randall</i>	

335046



10-11-76

305151

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR.
PAGES 4 & 5 TO THE MEDICAL EXAMINER. GIVE PERMITS TO THE CHIEF MEDICAL EXAMINER ALONG WITH
PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820

BP

DHMH - 17
(VR A15 ME (5))
15M7/77

FOR 1- STATE REGISTRAR		FOR DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				27292											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR ? M	
Louis						Hanzlik		10 20 19 85									
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 20 20		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD		10 21 19 85		1 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.											
10. CITY OR TOWN OF DEATH Essex		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1830 Holly Neck Rd. Essex, Md.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Crane Operator - Eastern Stainless Steel		12b. KIND OF BUSINESS OR INDUSTRY											
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Steel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1830 Holly Neck Rd. 21221									
4. FATHER'S NAME FIRST MIDDLE LAST Albert Hanzlik		5. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellanore Martin															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. KW 11 214-16-3222		17. INFORMANT Betty Hanzlik		ADDRESS 1830 Holly Neck Rd. 21221											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SUDDEN DEATH, PROBABLE VENTRICULAR</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARRHYTHMIA</u>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>HISTORY OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u>																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE <u>J. M. Niehoff</u>		TITLE (SPECIFY) M.D.		MEDICAL EXAMINER		DATE SIGNED <u>10/21/85</u> <u>21222</u>											
EXAMINER'S NAME (TYPE OR PRINT) <u>J. M. Niehoff, M. D.</u>		ADDRESS <u>6800 MORNINGTON RD. BALTIMORE, MD</u>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>10-25-85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holly Hills M.P. Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Co., Md.</u>											
24. FUNERAL DIRECTOR NAME <u>Lossahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd. BALTO. MD. 21234</u>		25a. DATE REC'D. BY REGISTRAR <u>OCT 28 1985</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson</u>											

12345678910111213141516171819202122232425262728293031323334353637383940414243444546474849505152535455565758596061626364656667686970717273747576777879808182838485868788899091929394959697989910010110210310410510610710810911011111211311411511611711811912012112212312412512612712812913013113213313413513613713813914014114214314414514614714814915015115215315415515615715815916016116216316416516616716816917017117217317417517617717817918018118218318418518618718818919019119219319419519619719819920020120220320420520620720820921021121221321421521621721821922022122222322422522622722822923023123223323423523623723823924024124224324424524624724824925025125225325425525625725825926026126226326426526626726826927027127227327427527627727827928028128228328428528628728828929029129229329429529629729829930030130230330430530630730830931031131231331431531631731831932032132232332432532632732832933033133233333433533633733833934034134234334434534634734834935035135235335435535635735835936036136236336436536636736836937037137237337437537637737837938038138238338438538638738838939039139239339439539639739839940040140240340440540640740840941041141241341441541641741841942042142242342442542642742842943043143243343443543643743843944044144244344444544644744844945045145245345445545645745845946046146246346446546646746846947047147247347447547647747847948048148248348448548648748848949049149249349449549649749849950050150250350450550650750850951051151251351451551651751851952052152252352452552652752852953053153253353453553653753853954054154254354454554654754854955055155255355455555655755855956056156256356456556656756856957057157257357457557657757857958058158258358458558658758858959059159259359459559659759859960060160260360460560660760860961061161261361461561661761861962062162262362462562662762862963063163263363463563663763863964064164264364464564664764864965065165265365465565665765865966066166266366466566666766866967067167267367467567667767867968068168268368468568668768868969069169269369469569669769869970070170270370470570670770870971071171271371471571671771871972072172272372472572672772872973073173273373473573673773873974074174274374474574674774874975075175275375475575675775875976076176276376476576676776876977077177277377477577677777877978078178278378478578678778878979079179279379479579679779879980080180280380480580680780880981081181281381481581681781881982082182282382482582682782882983083183283383483583683783883984084184284384484584684784884985085185285385485585685785885986086186286386486586686786886987087187287387487587687787887988088188288388488588688788888989089189289389489589689789889990090190290390490590690790890991091191291391491591691791891992092192292392492592692792892993093193293393493593693793893994094194294394494594694794894995095195295395495595695795895996096196296396496596696796896997097197297397497597697797897998098198298398498598698798898999099199299399499599699799899910001001100210031004100510061007100810091010101110121013101410151016101710181019102010211022102310241025102610271028102910301031103210331034103510361037103810391040104110421043104410451046104710481049105010511052105310541055105610571058105910601061106210631064106510661067106810691070107110721073107410751076107710781079108010811082108310841085108610871088108910901091109210931094109510961097109810991100110111021103110411051106110711081109111011111112111311141115111611171118111911201121112211231124112511261127112811291130113111321133113411351136113711381139114011411142114311441145114611471148114911501151115211531154115511561157115811591160116111621163116411651166116711681169117011711172117311741175117611771178117911801181118211831184118511861187118811891190119111921193119411951196119711981199120012011202120312041205120612071208120912101211121212131214121512161217121812191220122112221223122412251226122712281229123012311232123312341235123612371238123912401241124212431244124512461247124812491250125112521253125412551256125712581259126012611262126312641265126612671268126912701271127212731274127512761277127812791280128112821283128412851286128712881289129012911292129312941295129612971298129913001

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES E. HARMON						2a. DATE OF DEATH MONTH DAY YEAR 10-9-85 2b. HOUR MIN 7:45 PM					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 4, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County					
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stock Clerk			12b. KIND OF BUSINESS OR INDUSTRY Bedding		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD						13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles H. Harmon						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily O'Neill					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-207446		17. INFORMANT ADDRESS Sr. M. J. Edwards R.S.M., Balto., Md.							
18. CAUSE OF DEATH (Enter only one cause per line for Part I. Death was caused by.) IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ Splenic infarction Hypertension										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from 10-9 , 19 85 , to 10-9 , 19 85 , that (we) lost above the deceased alive on 10-9 , 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.											
22b. SIGNATURE E. Nethunde, M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										22c. DATE SIGNED 10-9-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. Nethunde, M.D.		22e. ADDRESS 7620 YORK ROAD TOWSON MD 21206									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-11-85		23c. NAME OF CEMETERY OR CREMATORY Baltimore				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Henry W. Jenkins & Sons Co., Balto., Md.						25a. DATE REC'D. BY REGISTRAR OCT 15 1985		25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the medical examiner, it should be detached for use as the burial-transit permit. Then please remove carbon copy and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner will be notified about it.

MEDICAL CERTIFICATION

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 2 9 4

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HENRIE L. HARRIS			2a. DATE OF DEATH MONTH DAY YEAR 10 - 1 - 85			2b. HOUR 3:37 PM			
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 21, 1920		6 AGE (IN YEARS LAST BIRTHDAY) 65 YRS		7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KENTUCKY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. COUNTY MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST JOSEPH HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME		
13a. STATE MARYLAND				13b. COUNTY BALTIMORE		13c. CITY OR TOWN 21204		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST HENRY SMITH				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA CAINES					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 407-12-1176		17. INFORMANT ADDRESS LUCILLE PANI IRONTON, OHIO 45638					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiogenic shock DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden 1/2 hr days hrs									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: hypertension									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Ca. R. King				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10/1/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (TYPE) BURIAL		23b. DATE OCT. 6, '85		23c. NAME OF CEMETERY OR CREMATORY HIGHLAND MEM. GARDENS		23d. LOCATION CITY OR TOWN COUNTY STATE SOUTH POINT, OHIO			
24. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON ADDRESS 8521 LOCH RAVEN BLVD.				25a. DATE REC'D. BY REGISTRAR OCT 2 1985		25b. REGISTRAR'S SIGNATURE John E. Anderson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 2 9 5

303035

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lottie		FIRST Harrison		LAST		2a. DATE OF DEATH MONTH DAY YEAR 10 22 85		2b. HOUR 1 A M	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 5 22 19		6. AGE IN YEARS (LAST BIRTHDAY) 66		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Roadstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. STATE MD		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8327 SCOTTS LEVEL RD. #21208	
14. FATHER'S NAME FIRST MIDDLE LAST HYMAN RUBENSTEIN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MOLLIE UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO 212-10-6514		17. INFORMANT HARRY HARRISON 8327 SCOTTS LEVEL RD. BALTO., MD 21208					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **PROBABLE SEPTIC SHOCK**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) **Polycthemia Vera**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **NO**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from JANUARY , 19 85 , to 10/22 , 19 85 , that (I) (we) lost saw the deceased alive on 10/22 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard A. Schlotman MD				DEGREE MD		22c. DATE SIGNED 10/22/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Schlotman				22e. ADDRESS 6000 Park Hts. AVE Baltimore, MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCT. 23, 1985		23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO (ARLINGTON)		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR OCT 28 1985			
				25b. REGISTRAR'S SIGNATURE J. H. Burdick			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be signed by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. Page 3 may be retained by the funeral director. The medical examiner must be notified at once. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

303032



MAHARAJA

Handwritten text at the bottom of the page, including a signature and some illegible notes.

291013

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon pages: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/B2
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		2b. HOUR	
Lorraine E Hasenei				Oct. 6, 1985		1:30am	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		MONTH DAY YEAR Apr 12 1927		58	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		Usa.				Baltimore County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Dundalk		6711 Oak Ave.		Balto. Co.		Driver	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
		Md.		Balto.		Dundalk	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		6711 Oak Ave. 21222	
George P Hasenei		Marie Isabell Bean					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		220-14-4403		Mary Edwards		6711 Oak Ave 21222	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiration Arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Malignant Fibrosarcoma.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS INVOLVED <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from _____, 19____, to <u>October 6, 1985</u> , that (1) we lost saw the deceased alive on <u>September 29, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) we (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<u>John H. Fetting M.D.</u>						10/8/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
John H. Fetting M.D.		Johns Hopkins Oncology Center.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		10/9/85		Oak Lawn		Balto. Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Connelly Funeral Home of Dundalk				OCT 16 1985		<u>John Davidson-Russell</u>	

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100% COTTON

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

302016

1. DECEASED NAME (TYPE OR PRINT) MARGARET		2a. DATE OF DEATH MONTH DAY YEAR 10 24 85		2b. HOUR 2:20A.M	
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 27 1934		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Woodlawn		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1906 Thayer Terrace		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13c. CITY OR TOWN BIVAVE		13b. STREET ADDRESS / ZIP CODE Box 71 B 21814	
FATHER'S NAME FIRST MIDDLE LAST Clarence E. White		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret C. Ricktor			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-30-5355		17. INFORMANT ADDRESS Margaret White 1906 Thayer Terrace 21207	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Breast Cancer DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 81 to Oct 19 85 , that (I) (we) last saw the deceased alive on Oct 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE Philip H. Konits		DEGREE PH.D.		22c. DATE SIGNED 10/24/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Philip H. Konits		22e. ADDRESS 606 Hammonds Lane			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/26/85		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.		ADDRESS 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR OCT 25 1985	
				25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed and retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages should be filed within 72 hours after death. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

305010

REGISTERED

WILLIAM W. CHILMAN



DEL SE REP

302004

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) THOMAS LEO HELLMAN			2a. DATE OF DEATH MONTH DAY YEAR OCT 20 1985			2b. HOUR M			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR DEC 4 1904		6. AGE (IN YEARS LAST BIRTHDAY) 80		7. UNDER 1 YEAR MONTHS DAYS YRS	
7a. BIRTHPLACE (STATE OR FOREIGN) BALTIMORE		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO COUNTY MD.			
10. CITY OR TOWN OF DEATH CATONSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 977 MASEFIELD AVE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY PLUMBING	
13a. STATE MD			13b. COUNTY BALTO		13c. CITY OR TOWN CATONSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST HENRY HELLMAN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE HIGGINS			16. STREET ADDRESS / ZIP CODE 977 MASEFIELD AVE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 816-09-3537		17. INFORMANT ADDRESS LOUISE T. HELLMAN MASEFIELD AVE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prostatic Carcinoma								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months	
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 7-15-85 , 19____, to 10-20-85 , 19____, that (I) (we) lost saw the deceased alive on 9-20-85 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Paul Gormley			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/21/85	
22d. (PHYSICIAN'S NAME (TYPE OR PRINT)) PAUL GORMLEY			22e. ADDRESS 900 CATON AVE BALTO MD 21229						
23a. BURIAL, CREMATION, REMOVAL SPECIFY BURIAL			23b. DATE 10/24/85		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD		
24. FUNERAL DIRECTOR NAME ADDRESS WEBER FUNERAL HOME EDMONDSON AVE			25a. DATE REC'D. BY REGISTRAR OCT 25 1985		25b. REGISTRAR'S SIGNATURE J. H. Harrison-Randall				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and family physician (if by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be certified as such.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 2 9 9

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELWOOD G HELWIG Sr			2a. DATE OF DEATH MONTH DAY YEAR 10 4 85		2b. HOUR 1738^M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10/28/13		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) FINKSBURG, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE Co. MD.	
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO. CO. GEN. HOSPT.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED BALTO. Co.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY BALTO.		13c. CITY OR TOWN REISTERSTOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST PHILIP O. HELWIG		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORENCE MURRAY		13e. STREET ADDRESS / ZIP CODE 6045 GLEN FALLS RD. 21136			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-14-9779		17. INFORMANT ADDRESS MRS. MAMIE B. HELWIG REISTERSTOWN, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electromechanical dissociation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Congestive Heart Failure							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: C.O.P.D., (R) Above Knee Amputation, (R) Pleural Effusion							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS NURSING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Hafeez A. Sreedhar				DEGREE		22c. DATE SIGNED 10/4/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. A. SYED				22e. ADDRESS BALTIMORE COUNTY GEN HOSP.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/8/85		23c. NAME OF CEMETERY OR CREMATORY FINKSBURG CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE FINKSBURG, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS ELINE FUNERAL HOME REISTERSTOWN, Md.				25a. DATE REC'D. BY REGISTRAR OCT 7 1985			
				25b. REGISTRAR'S SIGNATURE Fahia Davidson-Randall			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must investigate at once.

BP

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10/28/13

FINKSBURG, MD. USA BALTIMORE CO.

RANDALLSTOWN BALTO. CO. GEN. HOSPT. RETIRED BALTO. CO.

MD. BALTO. REISTERSTOWN BOON GLEN FALLS RD. 21138

PHILIP O. HELWIG FLORENCE MURRAY

214-14-272 Mrs. MAMIE B. HELWIG REISTERSTOWN, MD NO

BURIAL 10/28/82 FINKSBURG CEMETERY FINKSBURG, MD.

ELINE FUNERAL HOME REISTERSTOWN, MD.

295144

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with a 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 3 0 0

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Otto Leroy Hensel			2a. DATE OF DEATH MONTH DAY YEAR October 8, 1985		2b. HOUR 11:07pm			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 - 20 - 22		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Crane operator-Langenfelder&Son		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Otto Hensel			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Hartman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-18-1660		17. INFORMANT ADDRESS Rose A. Hensel 2432 Holly Neck Rd. 21221			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Cardiac death DUE TO, OR AS A CONSEQUENCE OF (b) chronic artery disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 84yrs								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 10 19 79 , to 10-8 19 85 , that (I) (we) lost saw the deceased above , (I) (we) did not see the body after death.								
22b. SIGNATURE Michael Rudicoff				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-9-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Rudicoff, M.D.				22e. ADDRESS 222 W. Coldspring Lane 21210				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10-12-85		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		
24. FUNERAL DIRECTOR NAME LASSAHN FUNERAL HOME				ADDRESS 7401 BELAIR		25. DATE REC'D. BY REGISTRAR OCT 15 1985		
				26. REGISTRAR'S SIGNATURE John E. ...				

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1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Benedict W. HEPNER			2a. DATE OF DEATH MONTH DAY YEAR October 16, 1985		2b. HOUR 4:50a M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 3 1918		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 67	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steel Worker		12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Chase		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 13103 Patuxant Road 21220		14. FATHER'S NAME FIRST MIDDLE LAST Martin Hepner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Madeline Not Known			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 216-05-1189		17. INFORMANT Josephine A. Hepner		ADDRESS Same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cardiogenic Shock DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial Infarction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 14, 1985 , to October 16, 1985 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 16, 1985 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (XXX) view the body after death.							
22b. SIGNATURE Kevin M. Miller MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/16/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kevin M. Miller, M.D.				22e. ADDRESS 9000 Franklin Square Dr., 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/18/1985		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Of Jesus		23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc.				25a. DATE REC'D. BY REGISTRAR OCT 18 1985			
7922 Wise Avenue Dundalk, Maryland 21222				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
EARL		T		HERMAN	10		30	85	3:24		P.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		White		8-16-15		70		MONTHS		DAYS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Balto., MD		USA				BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Towson		ST. JOSEPH HOSPITAL		Dispatcher		American Oil					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
MD				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5818 Cedonia Ave., 21206			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST		FIRST MIDDLE LAST									
Thomas		Herman		Sylvia							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No		215-09-5866		Mary Wade Herman, 5818 Cedonia Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		Baltimore, MD 21206								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a)		metabolic acidosis due to									
DUE TO, OR AS A CONSEQUENCE OF		(b) renal failure									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF									
		(c) Diabetes mellitus									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WOUND <input type="checkbox"/> NOT WOUND <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
Natividad D. de Leon, M.D.				10/30/85							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
NATIVIDAD D. DE LEON		C/o St. Joseph Hospital									
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR			
Burial		11-2-85		Baltimore Cem.		Balto.		Balto., MD			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
John C. Miller, Inc., 6415 Belair Rd. 21206		NOV 01 1985		John Davidson-Randall							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Paper must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by certified mail.

BP

30303



304201

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILLIAM F. HERMANI			2a. DATE OF DEATH MONTH DAY YEAR 10 15 '85			2b. HOUR 10:05A_M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 15 21		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY, MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER BALTIMORE MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS OR INDUSTRY Can	
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6516 Beechwood Rd. 21239	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Hermani				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII		17. INFORMANT ADDRESS Mrs. Barbara Hermani -Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) MASSIVE (L) CVA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) ASVD WITH HYPERTENSION APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0									
19a. DATE OF OPERATION 9/26/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED (L) CAROTID STENOSIS 4331				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/21 , 19 85 , to 10/15 , 19 85 , that (I) (we) last saw the deceased alive on 10/15 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Phillip N. Phillips MD						DEGREE MD		22c. DATE SIGNED 10/15/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PHILLIP N. PHILLIPS, M.D.				22e. ADDRESS GBMC - 6701 N. CHARLES STREET 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 10/15/85		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS = Balto., Md.		25a. DATE REC'D. BY REGISTRAR OCT 24 1985		25b. REGISTRAR'S SIGNATURE <i>Wm Davidson-Randall</i>	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18, then any injury, or other traumatic cause of death, must be notified at once to the medical examiner.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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MILITARY

290005

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 3 0 4

FOR
1 - STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) MILDRED E. HERSHEY			2a. DATE OF DEATH MONTH DAY YEAR OCT. 12, 1985		2b. HOUR 9 1/4 AM						
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept 2, 1915		6 AGE (IN YEARS LAST BIRTHDAY) 70		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 70		IF UNDER 24 HRS. HOURS MIN. 70	
7 BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
10 CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland				13b. COUNTY Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 2731 Evergreen Ave 21206			
14 FATHER'S NAME FIRST MIDDLE LAST John A Parks				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Long							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-14-9343		17 INFORMANT ADDRESS Norman H Hershey Sr 3781 Font Hill Manor Dr							

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Kennedy's CirrhosisAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**4pm**

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 80 to 10-12 19 85 that (I) (we) last saw the deceased alive on 10-12 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.							
22b. SIGNATURE Calvin H. Stoner		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-15-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert E. Stoner MD		22e. ADDRESS 714 York Rd. Towson 21204					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/15/85		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR OCT 15 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or hospital, it should be detached for use on the burial/transit permit. Their permit requires carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is completed on item 18 shows any injury, or other traumatic event, then medical examiner must be notified at once.

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WILLIAM E. HENNEY OCT 1914

WILLIAM E. HENNEY

WILLIAM E. HENNEY



WILLIAM E. HENNEY

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WILLIAM E. HENNEY

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ROBERT JAMES HESTER III						2a. DATE OF DEATH MONTH DAY YEAR 10 28 85		2b. HOUR 10⁵⁴ PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 4 29		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) G.BMC				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired - U.S. Public Health		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Monkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
14. FATHER'S NAME FIRST MIDDLE LAST Robert J. Hester, Jr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Thomas			13e. STREET ADDRESS / ZIP CODE 2811 Monkton Manor Rd. 21111					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW II 239-36-8888		17. INFORMANT ADDRESS Alverta L. Hester - Same as #13e						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE											
DUE TO, OR AS A CONSEQUENCE OF (c) OBESITY											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) HYPERTENSION											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3/9 , 19 85 , to 10/22 , 19 85 , that (I) (we) lost saw the deceased alive on 10/22 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Walter R. Hester III MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10/29/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER R. HESTER III MD			22e. ADDRESS 3313 PABENMILL RD PHOENIX MD 21131								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-1-85		23c. NAME OF CEMETERY OR CREMATORY Clynmalaria Methodist		23d. LOCATION CITY OR TOWN COUNTY STATE Monkton Balto. Md.				
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204			ADDRESS 1050 York Rd.			25a. DATE REC'D. BY REGISTRAR NOV 04 1985		25b. REGISTRAR'S SIGNATURE [Signature]			

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294009

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) Howard E. Heuisler			2a DATE OF DEATH MONTH DAY YEAR 10 13 85		2b HOUR		
3 SEX Male		4 RACE Cau.		5 DATE OF BIRTH MONTH DAY YEAR 3 22 09		6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Balto. County MD.	
10 CITY OR TOWN OF DEATH Balto.		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hosp.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer		12b KIND OF BUSINESS OR INDUSTRY Retired	
13a STATE Md.		13c CITY OR TOWN Balto.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 3915 Fleetwood Ave. 21206	
14 FATHER'S NAME FIRST MIDDLE LAST Harry Heuisler			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Kricton				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. 216-09-4393		17 INFORMANT ADDRESS Elizabeth H. Heuisler 3915 Fleetwood Ave.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) POSSIBLE MASSIVE M.I. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 1981 , 19____, to _____, 19____, that (I) (we) last saw the deceased alive on September 11, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Donato A. Vargas, Jr.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED	
22d PHYSICIAN'S NAME (TYPE OR PRINT) DONATO A. VARGAS, JR.		22e ADDRESS 4706 HARFORD RD. BALTO. MD. 21214					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10-17-85		23c NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d LOCATION CITY OR TOWN COUNTY STATE Balto. Balto. Md.	
24 FUNERAL DIRECTOR NAME John C. Miller Inc. 6415 Belair Rd.				25a DATE REC'D. BY REGISTRAR OCT 17 1985			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be recited within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

INFORM

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10-100-1. THIS CERTIFICATE SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/77

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

27307
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Edward			MIDDLE J			LAST Hoben			2b. DATE KNOWN OF DEATH ESTIMATED			MONTH 10			DAY 3			YEAR 1985			2d. HOUR 10 PM									
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR Oct. 7 1902			6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.			IF UNDER 1 YR. MONTHS DAYS HOURS MIN.			IF UNDER 24 HRS. HOURS MIN.			2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 3 1985			2d. HOUR 10 PM												
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. COUNTY MD.																								
10. CITY OR TOWN OF DEATH Randallstown			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balto. County Hospital															12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance			12b. KIND OF BUSINESS OR INDUSTRY Plumbing												
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md. CARROLL COUNTY															13b. CITY OR TOWN Sykesville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 668 Oakland Mills Rd.												
14. FATHER'S NAME FIRST MIDDLE LAST Unk						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia ?																											
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No						16b. SOCIAL SECURITY NO. 220 03 1589						17. INFORMANT ADDRESS Gertrude Hoben - Sykesville, Md.																					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Cardio Vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE																					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																																	
ACTUAL SIGNATURE E. P. Williams						TITLE (SPECIFY) Deputy						MEDICAL EXAMINER						DATE SIGNED 10/4/85															
EXAMINER'S NAME (TYPE OR PRINT) E. P. Williams						ADDRESS 5550 BALTONAILE RD 21225																											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 10-6-85						23c. NAME OF CEMETERY OR CREMATORY Providence Cemetery						23d. LOCATION CITY OR TOWN COUNTY STATE Gambler, Carroll County Md.															
24. FUNERAL DIRECTOR NAME Harry W. Haight												ADDRESS Sykesville, MD												25. DATE REC'D. BY REGISTRAR OCT 7 1985									

TS1525

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

282045

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO. 85 27308	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret H. Hoffnagel			2. DATE OF DEATH MONTH DAY YEAR October 5, 1985		2b. HOUR 9:13A M
3. SEX Female		4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 1-28-1901		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Essex		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Samstress-Retired Butler Bros.	
13a. STATE Md.		13b. COUNTY Balto.	13c. CITY OR TOWN Balto.	13e. STREET ADDRESS / ZIP CODE 8710 Wendell Ave.-21234	
14. FATHER'S NAME FIRST MIDDLE LAST William Conrades			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Effie Hopkins		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 217-01-5399		17. INFORMANT Harry F. Webb Jr.-2317 Ellen Ave.-21234	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest, Chronic cardiac failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probable acute pulmonary embolus</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>September 12, 1985</u> to <u>October 5, 1985</u> that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>October 5, 1985</u> and that in <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, <u>(I/we)</u> did <u>(do not)</u> view the body after death.					
22a. SIGNATURE <u>Goehlert MD.</u>		DEGREE		22c. DATE SIGNED 10/5/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Uwe Goehlert, MD</u>		22e. ADDRESS 9000 Franklin Square Drive 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-8-85	23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.
24. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd. OCT 7 1985 <u>[Signature]</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

07/84
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DHMH - 17
(VR A15 ME (5))

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 7 3 0 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH		DAY		YEAR		2b. HOUR	
George						Holley		10		12		85				M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		8. MONTH		9. DAY	
M		B		4 6 64		21 YRS.						10		12		85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland		U.S.A.				Baltimore County,										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		Lerely & Day Cove Roads															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Balt		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		353 Loreley Rd. 21162									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
George		Agnes		Yes		218-72-3697		George K. Holley Sr.		353 Loreley							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
				Gunshot wound of neck													
				(b)		DUE TO, OR AS A CONSEQUENCE OF											
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		3:30 PM 10-12-85		Subject shot													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
		street		Lerely & Day Cove Rds,		Balto.		MD									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY)		DATE SIGNED													
ACTUAL SIGNATURE		M.D.		10/12/85													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Thomas D. Smith, M.D.		111 Penn St. Balto.MD.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
BURIAL		10-17-85															
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
W.C. March F/H Co.		1101 E. North Ave.		OCT 15 1985		Julia Davidson-Randall											

230012

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1- FOR
STATE
REGISTRAR

XC 02762145

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 3 1 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
JOHN		AUGUST	HOLMES	Sr.	OCTOBER 19, 1985				11:35 A
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE	WHITE	JANUARY 16, 1898		87	MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND	U.S.A.			BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
FORT HOWARD	VA MEDICAL CENTER		PRINTING PRESSMAN		PUBLISHING				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE			
MARYLAND		ANNE ARUNDEL	Baltimore	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	619 REGATTA AVENUE/21225				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
JACOB		Katherine Eisenhardt							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
YES		W.W. I		212 07 3579		John A. Holmes Jr 627 Biscay Ave Balto Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA OF THE PANCREAS</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>SEPTEMBER 26</u> , 19 <u>85</u> , to <u>OCTOBER 19</u> , 19 <u>85</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>OCTOBER 19</u> , 19 <u>85</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.									
22b. SIGNATURE <i>Marcia Kane MD</i>				DEGREE			22c. DATE SIGNED		
				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			10-19-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
MARCIA KANE, M.D.				VA MEDICAL CENTER, FORT HOWARD, MD 21052					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. COUNTY	
Burial		10/23/85		Md Vets Cemetery		Crownsville		A.A. Md	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
George J. Gonce 4001 Ritchie Hwy Balto Md				OCT 22 1985		<i>John A. Holmes Jr</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon pages. Page 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

1917

20% COLLECTIBLE



George E. Loefer, 4001 Atlantic Hwy. Suite 101

10/15/17 and late summer

Monroeville, A.A.

297016

DIVISION OF VITAL RECORDS, 201 W. PRESIDENT, BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSMITTAL. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESIDENT STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25MBP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

27311
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH		DAY		YEAR		20. HOUR	
HERBERT		L.				HOOVER, Sr.		10		13		19		85		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	White	Apr. 1, 1948		37 YRS.						10		13		19		85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								MD	
Maryland		USA						Baltimore County									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Sparks		15221 Tanyard Rd.		Carpenter		Home Building											
13a. STATE		13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Baltimore		Sparks		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		15221 Tanyard Rd./21152									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Harry A. Hoover, Sr.		Dorothy E. Brown															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		213-46-0063		Christine A. Cutlip, Glen Rock, PA 1732													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) <u>Gunshot wound of head (handgun)</u>		DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)		10xxx 10-13- 19 85		Self-inflicted.									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		driveway		15221 Tanyard Rd., Sparks, Balto.						MD							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:		Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY)		M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED		10-14-85					
ACTUAL SIGNATURE		Ann M. Dixon, M.D.		ADDRESS		111 Penn St., Balto., MD		21201									
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE					
Burial		Oct. 17, 1985		Rosley U.M.		Sparks, Baltimore, MD											
24. FUNERAL DIRECTOR		NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
J.J. Hartenstein		New Freedom, PA 17349		OCT 21 1985		J. J. Hartenstein											

20012

212-40-1013



296156

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (1))

Filing G614 item 5&6 STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										2 / 3 1 2 REG. NO.	
1- FOR STATE REGISTRAR 4/18/86 rja											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST TERESA E. HOOVER										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 10 13 1985	
3 SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 25, 1948		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 29 YRS.		7c. DATE PRONOUNCED DEAD 10 13 1985		2d. HOUR 10:10	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD				7b. CITIZEN OF WHAT COUNTRY? USA				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD	
10 CITY OR TOWN OF DEATH Sparks				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 15221 Tanyard Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE MD				13b. CITY OR TOWN Baltimore		13c. CITY OR TOWN Sparks		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 15221 Tanyard Rd./21152	
14 FATHER'S NAME FIRST MIDDLE LAST O. Kenneth Simmons, Sr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Norma E. Isennock					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No						16b. SOCIAL SECURITY NO. 219-58-1886		17 INFORMANT ADDRESS 14155 Manchester St. Christine Cutlip Glen Rock, PA 17327			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple gunshot wounds (handgun)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10 AM 10-13- 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject shot.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) driveway		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 15221 Tanyard Rd., Sparks Balto. MD					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 10-14-85			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., MD 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE (SPECIFY) Oct. 17, 1985		23c. NAME OF CEMETERY OR CREMATORY Bosley United Meth.		23d. LOCATION CITY OR TOWN COUNTY STATE Sparks, Baltimore, Md.			
24 FUNERAL DIRECTOR NAME J.J. Hartenstein				25a. DATE REC'D. BY REGISTRAR Oct 21 1985				25b. REGISTRAR'S SIGNATURE 			

501110

2281 22-110

— 2281 —

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 3 1 3

1- FOR
STATE
REGISTRAR

REG. NO.

282125

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT E. HOWELL			2a. DATE OF DEATH MONTH DAY YEAR 10-5-1985		2b. HOUR 12:04 PM						
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 01 16 1916		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 69		8. IF UNDER 24 HRS. HOURS MIN. 12 04	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) COVINGTON KY.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CO. MD.					
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO. CO. GEN. HOSPT.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED OUTRIDER				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN REISTERSTOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13. STREET ADDRESS / ZIP CODE 1 CHERRY HILL CT. 21136			
14. FATHER'S NAME FIRST MIDDLE LAST RICHARD HOWELL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST STANLEY KELLEY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2 079-16-1485		17. INFORMANT ADDRESS MRS. GLADYS L. HOWELL REISTERSTOWN, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic Shock DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Perforated Colon DUE TO, OR AS A CONSEQUENCE OF (c) Diverticulitis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 9-29 , 19 85 , to 10-05 , 19 85 , that (I) (we) last saw the deceased alive on 10-05 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Allen J. Chircus M.D.								DEGREE M.D.		22c. DATE SIGNED 10-05-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Allen J. Chircus M.D.								22e. ADDRESS Baltimore County General Hosp.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/8/85		23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST CEM. OWINGS MILLS, MD.				23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME ELINE FUNERAL HOME REISTERSTOWN, MD.								25a. DATE REC'D. BY REGISTRAR OCT 7 1985		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

282135



X

BALTIMORE CO.

COVINGTON KY. USA

RANDALLSTOWN BALTO. CO. GEN. HOSPT. RETIRED OUTRIDER

1 CHERRY HILL CT. 21156

MD. BALTO. REISTERSTOWN

KELLEY

STANLEY

HOWELL

RICHARD

079-16-145 Mrs. GLADYS L. HOWELL REISTERSTOWN, MD.

YES WM S

BURIAL 10/8/85 GARRISON FOREST CEM. CHINGS MILLS, MD.

ELINE FUNERAL HOME REISTERSTOWN, MD.

283125

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 3 1 4

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Georgia Cleveland Mason Hubbard			2a. DATE OF DEATH MONTH DAY YEAR 10 6 85			2b. HOUR 5:40 P.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 06 23 07		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. ---		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST JOSEPH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY ---		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3606 Briarstone Rd. 21133	
14. FATHER'S NAME FIRST MIDDLE LAST unknown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nan Madison							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-36-8278B		17. INFORMANT Baltimore, MD 21214 William H. Hubbard II 2705 Shirey Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute CVA DUE TO, OR AS A CONSEQUENCE OF (b) Severe Ischemic Heart DUE TO, OR AS A CONSEQUENCE OF (c) Down with aortic fibrillation PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) COPD, Hypertensive Arterial Disease									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Gracita V. Patricia					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10/7/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gracita V. Patricia					22e. ADDRESS St. Joseph Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-9-85		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore MD			
24. FUNERAL DIRECTOR NAME ADDRESS Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133					25a. DATE REC'D. BY REGISTRAR OCT 8 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and a copy filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, it is important that a medical examiner be notified of cause.

528132



ADDITIONAL NOTION OF

WINDY WINTER

308074

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

B 5 2 7 3 1 5

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Sister Mary CLAUDE HUDLIN</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>10-28-85</i>			2b. HOUR <i>6-15p.m.</i>	
3. SEX <i>Female</i>		4. RACE <i>BLACK</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>8 3 '96</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>89</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Missouri</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE COUNTY MD.</i>	
10. CITY OR TOWN OF DEATH <i>Catonsville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>701 Gun Road</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired-Nun</i>	
13a. STATE <i>Md</i>		13b. COUNTY <i>Balto</i>		13c. CITY OR TOWN <i>Balto</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Richard</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Barbara Rutger</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>			
16b. SOCIAL SECURITY NO. <i>NA</i>		17. INFORMANT ADDRESS <i>Sister Mary Virginie Fish 701 Gun Road</i>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>SEPTICEMIA</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>URINARY TRACT INFECTION</i>			
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Congestive heart failure ASCVD</i>			
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19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
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22b. SIGNATURE <i>Baskaran M.D.</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>10-29-85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. SAMBANDAM BASKARAN</i>				22e. ADDRESS <i>3455 Wilkens Ave Baltimore MD 21229</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>11/1/85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Md</i>	
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24. FUNERAL DIRECTOR NAME <i>William C. March F/H West</i>		ADDRESS <i>4300 Wabash Avenue</i>		25a. DATE REC'D. BY REGISTRAR <i>OCT 31 1985</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

308074



290067

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
Della A. Huffman			10 11 85			930 P M		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Female	White	June 20, 1901		84		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland	U.S.A.			Baltimore County MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Towson	Multi Medical Center			Retired- B&O		Railroad		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS				
Maryland	City	Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3543 Pelham Ave. 21213				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
Clarence Altwater			Bertie McNeal					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO			705-07-3788		John V. Altwater, Rt. 1, Box 239 Trappe, Md. 21673			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of pancreas</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from <u>8/21</u> 19 <u>85</u> to <u>10/11</u> 19 <u>85</u> , that (1) (we) lost saw the deceased alive on <u>10/11</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death.								
22b. SIGNATURE <u>Carl S. Friedman, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>10/11/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Carl S. Friedman, M.D.</u>				22e. ADDRESS <u>660 Kenilworth Drive Towson, Md. 21204</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial		10-14-85		Parkwood Cemetery		Parkville, Maryland		
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. ADDRESS 1050 York Rd. Towson, Md. 21204				25. DATE REC'D. BY REGISTRAR OCT 15 1985				
				25b. REGISTRAR'S SIGNATURE <u>Julia Davidson</u>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

NOTICE



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 3 1 7

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Melvin M. HUME			2a. DATE OF DEATH MONTH DAY YEAR October 24, 1985		2b. HOUR 11:17a_M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 26 1903		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED** NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Steelworker	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> **	
14. FATHER'S NAME FIRST MIDDLE LAST Howard Hume		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Edwards		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 193-01-3315	
17. INFORMANT ADDRESS Juanita Borgerding 8409 Harris Ave. 21234		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma of the Prostate DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 15, 1985 , to October 24, 1985 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 24, 1985 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) did not view the body after death.							
22b. SIGNATURE <i>K.C. Kitchen</i> MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-24-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K.C. Kitchen, M.D.				22e. ADDRESS 9000 Franklin Square Drive Balto. , MD 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/26/85		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Middle River Balto. Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Connolly Funeral Home 300 Mace Ave. 21221				25a. DATE REC'D. BY REGISTRAR OCT 30 1985		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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RECEIVED NOV 10 1963

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BP

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(VRA 15, 4)

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 3 1 8

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) RICHARD R. HUNTER			2a DATE OF DEATH MONTH DAY YEAR 10-11-85			2b HOUR 2:15^a M				
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR June 12, 1985		6 AGE IN YEARS (LAST BIRTHDAY) ✓ 88 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore, Co. MD.				
10 CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Real Estate		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.			13b COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 3505 Parkside, Drive	
14 FATHER'S NAME FIRST MIDDLE LAST William R. Hunter				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Roberts						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 713-01-5423		17 INFORMANT ADDRESS William R. Hunter Sr. 3605 Parkside Drive					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation DUE TO, OR AS A CONSEQUENCE OF (b) Anterior Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) Bronchogenic Carcinoma of Lung								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 minute		
								20 hours		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Hypercalcemia										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from 10/5/ 19 85 to 10/11 19 85 , that (I) (we) last saw the deceased alive on 10/11 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE Michael Drossner						DEGREE MD		22c DATE SIGNED 10/11/85		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Michael Drossner						22e ADDRESS St. Joseph Hospital, 7620 York Road, Baltimore MD				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 10-14-85		23c NAME OF CEMETERY OR CREMATORY Parkwood		23d LOCATION COUNTY Md. STATE			
24 FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. 5305 Harford Rd.						25a DATE REC'D. BY REGISTRAR OCT 14 1985		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

B 5 2 7 3 1 9

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Richard R. Hyde			2a. DATE OF DEATH MONTH DAY YEAR October 25, 1985			2b. HOUR M			
3. SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 9, 1906		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Parkville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8360 Ridgley Oak Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Parkville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST William J. Hyde			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret McCrone Yoe			13e. STREET ADDRESS / ZIP CODE 8360 Ridgley Oak Rd. 21234			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-14-4873		17. INFORMANT ADDRESS Robert J. Flaherty 8313 Edgedale Rd. 21234					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - C.V.A. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Hypertension.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11/1/80 to 8/24/81, that (I) saw the deceased alive on 10/25/85, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.									
22b. SIGNATURE M.D. <i>W. J. Flaherty</i>				22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Khin Tun				22e. ADDRESS 1006 Taylor Ave					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct 29 1985		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. 5305 Harford Rd. 21214				25a. DATE REC'D. BY REGISTRAR OCT 28 1985		25b. REGISTRAR'S SIGNATURE <i>W. J. Flaherty</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

298013

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Mary Jackowiak		2a. DATE OF DEATH MONTH DAY YEAR October 20, 1985		2b. HOUR M 4:45p	
3 SEX FEMALE	4 RACE CAUC.	5. DATE OF BIRTH MONTH DAY YEAR 12 15 01		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10 CITY OR TOWN OF DEATH BALTIMORE CO.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. CITY OR TOWN BALTIMORE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST JOSEPH WISNIEWSKI		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE BANDZWOLEK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS WILLIAM BETHKE 229 SIPPLE AVE 21236	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardio-Respiratory ArrestAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHConditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

Ventricular Arrhythmia

DUE TO, OR AS A CONSEQUENCE OF

Atherosclerotic Cardio Vascular Disease

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from October 20, 1985 to October 20, 1985 that (I) (we) last saw the deceased alive on October 20, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert H. Wiedefeld M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-20-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert H. Wiedefeld, M.D.				22e. ADDRESS 9000 Franklin Square Drive 21237			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/24/85		23c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS KACZOROWSKI FUNERAL HOME 2525 FLEET ST. 21224				25a. DATE REC'D. BY REGISTRAR OCT 23 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician, and that the death certificate be filed with the health department within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

338013

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Mary Louise Jantzen			2a. DATE OF DEATH MONTH DAY YEAR 10 8 85			2b. HOUR 1:55 P.M.			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 5 1919		6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10 CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Heritage Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8118 Bullneck Rd. 21222	
14. FATHER'S NAME FIRST MIDDLE LAST Clyde Franklin Hicks				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora Ann Cromley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219/26/2752		17. INFORMANT ADDRESS William F. Jantzen (same as 13e.)					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL INFARCTION (Bilateral)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			
DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITUS.			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: HYPERTENSION, HERNIA.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/15/1983 to 10/8/1985, that (I) (we) lost saw the deceased alive on 10/8/1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE W. J. HARMASANA MD.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/8/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. J. HARMASANA				22e. ADDRESS 28, 16th AVE. BALTO. MD. 21225			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/11/85		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Walter Brooks Bradley Inc. Balto., Md. 21222				25a. RECEIVED BY REGISTRAR 06710 1985		25b. REGISTRAR'S SIGNATURE John Davidson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

211282



304082

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5 27322

1. DECEASED NAME (TYPE OR PRINT) GEORGE G. JENKINS			2a. DATE OF DEATH MONTH DAY YEAR 10 26 85			2b. HOUR 4:50 A.M.			
3 SEX MALE		4 RACE CAU		5. DATE OF BIRTH MONTH DAY YEAR 2 16 98		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 87 YRS.		7. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) G.B.M.C. 6701 North Charles St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY MVA	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3101 Belair Rd. 21213	
14. FATHER'S NAME FIRST MIDDLE LAST Charles S. Jenkins				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Jane Jones					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-09-1348		17. INFORMANT ADDRESS Cockeysville, Records-Maryland Masonic Homes Md. 21030					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10/25 19 85 , to 10/25 19 85 , that (I) (we) last saw the deceased alive on 10/26 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John E. Adams				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10/28/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN E. ADAMS, M.D.				22e. ADDRESS 6701 N. CHARLES STREET 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 30, 1985		23c. NAME OF CEMETERY OR CREMATORY Baltimore		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212				25a. DATE REC'D. BY REGISTRAR JUL 29 1985		25b. REGISTRAR'S SIGNATURE John E. Adams			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

304083

BOX 304083

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)		2a DATE OF DEATH		2b HOUR	
FIRST MIDDLE LAST SOPHIA JOHNS		MONTH DAY YEAR OCTOBER 29, 1985		4:35 AM	
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
FEMALE	WHITE	MONTH DAY YEAR JUNE 18, 1904		81 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND	U.S.A.			BALTIMORE COUNTY, MD.	
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY
21234	8350 RIDGELY OAK ROAD		HOMEMAKER		HOME
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a STATE		13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	
MARYLAND		BALTIMORE	21234	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST WILLIAM TUDOR		FIRST MIDDLE LAST SOPHIA BAUER			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS	
NO		214-56-0495		MARIA BISKER 8350 RIDGELY OAK RD. 21234	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF <u>Heart disease</u> (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF <u>Emphysema</u> (c) <u></u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>June 20, 191985</u> to <u>Oct 29, 1985</u> , that (I) (we) last saw the deceased alive on <u>10/26</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE		22c ADDRESS		22d DATE SIGNED	
<u>Samuel Rubin M.D.</u>				<u>10/1/85</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS			
SAMUEL RUBIN, M.D.					
23a BURIAL, CREMATION, REMOVAL		23b DATE		23c NAME OF CEMETERY OR CREMATORY	
BURIAL		NOV. 1, '85		GLEN HAVEN MEM. PARK	
24 FUNERAL DIRECTOR		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
NAME ADDRESS WILLIAM E. JOHNSON 8521 LOCH RAVEN BLVD.		NOV 01 1985		<u>William E. Johnson</u>	
23d LOCATION		23e COUNTY STATE			
CITY OR TOWN ANNE ARUNDEL CO., MD					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

309025



287019

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5

2 7 3 2 4

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Irene E. Johnson</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>10-5-85</i>		2b. HOUR <i>5 A M</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>10-05-01</i>		
6. AGE (IN YEARS LAST BIRTHDAY) <i>84</i> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.						
10. CITY OR TOWN OF DEATH <i>Catonsville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Spring Grove Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		
12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Unknown</i>		13c. CITY OR TOWN <i>Unknown</i>		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>Unknown</i>				
14. FATHER'S NAME FIRST MIDDLE LAST <i>George Bloomstine</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Magdalena Fanner</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>213-50-7290</i>		17. INFORMANT ADDRESS <i>John H. Hessey, IV, 1311 Fidelity Bldg. 21201</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio pulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Organic Brain syndrome</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>A S CVD</i> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), (b), (c), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>9-10-19-85</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>9-10-19-85</i> to <i>10-5-19-85</i> , that (I) (we) lost saw the deceased alive on <i>10-5-19-85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>H. Devadoss</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>10/5/85</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>H. DEVADOSS</i>		22e. ADDRESS <i>Spring Grove Hospital</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Oct. 10, 1985</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Nat'l.</i>		
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore</i>		23e. DATE REC'D. BY REGISTRAR <i>9 1985</i>				
23f. REGISTRAR'S SIGNATURE <i>John Davidson-Henderson</i>		23g. REGISTRAR'S SIGNATURE				
24. FUNERAL DIRECTOR NAME ADDRESS <i>ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Balto., Md. 21214</i>						

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 5 2 7 3 2 5
FOR 1 - STATE REGISTRAR										REG. NO.
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HALLET LEE JONES					2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 8, 1985		2b. HOUR 9:15 A M			
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR APRIL 22, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.				
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND					13b. CITY OR TOWN BALTIMORE		13c. STREET ADDRESS / ZIP CODE 6816 FORT SMALLWOOD ROAD 21226			
14. FATHER'S NAME FIRST MIDDLE LAST LEE JONES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE MC INTYRE		17. INFORMANT ADDRESS Howard Jones 6816 Fort Smallwood Road CLINICAL RECORDS, VAMC, FORT HOWARD, MD						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 183 12 2588								
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) CARDIOPULMONARY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC HEART DISEASE END STAGE RENAL DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HOURS 10 YEARS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: ARTERIOSCLEROTIC HEART DISEASE END STAGE RENAL DISEASE										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22. I certify that (I) (this hospital) attended the deceased from JULY 21 , 19 85 , to OCTOBER 8 , 19 85 , that (I) (we) lost saw the deceased alive on OCTOBER 8 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated shows (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE <i>Waclaw J. Kazimierzczak</i>				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/8/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WACLAW J. KAZIMIERCZAK, M.D.				22e. ADDRESS VA MEDICAL CENTER FORT HOWARD, MD 21052						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10-11-85		23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST VA		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE COUNTY MARYLAND				
24. FUNERAL DIRECTOR NAME W.C. MARCH F/H CO.				ADDRESS 1101 E. NORTH AVE.		25. DATE REC'D. BY REGISTRAR 10/10/85				
				25b. REGISTRAR'S SIGNATURE <i>John Davidson-Henderson</i>						

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 3 2 6

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PASTY V. Jones			2a. DATE OF DEATH MONTH DAY YEAR 10/18/85			2b. HOUR 7-01 PM				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 3/19/37		6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO, COUNTY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.				
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE CO. GENERAL HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY BALTIMORE		13c. CITY OR TOWN REISTERSTOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 310 WEMBLEY RD. 21136	
14. FATHER'S NAME FIRST MIDDLE LAST ROY JACOBS SR.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MILDRED D. KETCHUM							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 213-34-0657		17. INFORMANT ADDRESS BILL H. JONES 310 WEMBLEY RD. 21136					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastasis carcinoma of lungs DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a Dehydration, Hypercalcemia										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/30/85 to 9/18/85, that (I) (we) last saw the deceased alive on 9/18/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE R-M. SHAH M.D.					DEGREE		22c. DATE SIGNED 10/18/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R-M. SHAH.					22e. ADDRESS Baltimore County General Hospital Randallstown, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/18/85		23c. NAME OF CEMETERY OR CREMATORY GARDEN OF FAITH		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD.			
24. FUNERAL DIRECTOR NAME ELINE FUNERAL HOME REISTERSTOWN, MD.					25a. DATE REC'D. BY REGISTRAR OCT 21 1985		25b. REGISTRAR'S SIGNATURE John Williams			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ELINE FUNERAL HOME REGISTERSTOWN, MO.

BURIAL

10/16/85

GARDEN OF FAITH

BALTIMORE,

MO.

NO

ROY

JACOBS SR.

MILDED

O.

KETCHUM

BALTIMORE REGISTERSTOWN

I.D.

310 WEMBLEY RD. 51136

RANDALLSTOWN

BALTIMORE CO. GENERAL HOSP. HOUSEWIFE

BALTO, COUNTY

U.S.A.

X

BALTIMORE COUNTY

FEMALE

WHITE

48

V.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 2 7 3 2 7
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Thomas Preasley Jones			2a. DATE OF DEATH MONTH DAY YEAR October 12, 1985			2b. HOUR 5:10 AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 2, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 76		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Freight		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Harford		13c. CITY OR TOWN Joppa		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1408 Alexis Drive 21085	

14. FATHER'S NAME FIRST MIDDLE LAST Samuel -- Jones			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Toney -- Abbott		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 579-09-4292		17. INFORMANT ADDRESS Mrs. Dorothy Jones, 1408 Alexis Drive, Joppa, Md. 21085	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma			
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

Aortic Aneurysm ; Chronic Obstructive Pulmonary Disease

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from October 1, 1985, to October 12, 1985, that (I) (we) last saw the deceased alive on October 12, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <i>BK Mahoney</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-12-985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>PR Mahoney</i>				22e. ADDRESS 9000 Franklin Square Dr. 21237			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 15, 1985		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens, Bel Air		23d. LOCATION CITY OR TOWN COUNTY STATE Harford Md.	
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE OCT 18 1985 <i>Jana Davidson-Hendall</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GENEVIEVE M. JORDAN			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 16, 1985		2b. HOUR 640 P.M.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 11 15		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO. MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.
10. CITY OR TOWN OF DEATH BALTO COUNTY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND			13b. COUNTY BALTO.	13c. CITY OR TOWN PARKVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ARCHIE MUMMA			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DELLA WILSON			13e. STREET ADDRESS / ZIP CODE 2912 GARNET AVE., 21234
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN		16b. SOCIAL SECURITY NO. 216-03-8756		17. INFORMANT ADDRESS		
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ALCOHOL</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>[Signature]</u>				DEGREE		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S.E. HARRIS				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
				22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCT. 19, 1985		23c. NAME OF CEMETERY OR CREMATORY FORK UNITED METHODIST CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE FORK BALTO. CO. MD.
24. FUNERAL DIRECTOR EVANS FUNERAL CHAPEL				25a. DATE REC'D. BY REGISTRAR OCT 22 1985		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be immediately filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

398150

OCTOBER 15, 1955

JORDAN

GEN EVIDENCE

TO

12

11

10

WHITE

RECEIVED

BALTIMORE COUNTY

ST. JOSEPH HOSPITAL

CALTE COUNTY

2125

1212 CARLETT AVE.

BALTIMORE

11E-01-8750

Handwritten signature

Handwritten signature

Handwritten signature

DEC 22 1955

2970

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
20M 4/821 FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH2 7 3 2 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ROBERT S JORDAN			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 19 02 07 3			2b. HOUR M 5 21		
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 4-1-1912	6. AGE (IN YEARS) LAST BIRTHDAY 73 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 02 07 3		7d. HOUR M 5 21
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plant Manager-Maryland Housing		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4401 Ridge Road Balto., 21236
14. FATHER'S NAME FIRST MIDDLE LAST Robert S. Jordan, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Flora Gay					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 232-22-9509		17. INFORMANT ADDRESS Mrs. Hazel Jordan 4401 Ridge Rd. 21236			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC AND HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) TENSIVE CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE DR. F. GUERIN			M.D. Deputy			DATE SIGNED 10/4/85		
EXAMINER'S NAME (TYPE OR PRINT) DR. F. GUERIN			ADDRESS 1311 WESTERN RUN RD COCKEYVILLE MD 21030					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-5-85		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Balto., Md.		
24. FUNERAL DIRECTOR NAME LASSAUN FUNERAL HOME BELAIR ADDRESS 7401				25a. DATE REC'D. BY REGISTRAR Oct 22 1985		25b. REGISTRAR'S SIGNATURE J. L. Taylor		

DHMH - 17
(VR A15 ME (5))
20M 4/82

Robert E. Jordan

RECEIVED 2 10 1972

OLD 1 1 1972

1-1-1972

Baltimore County

W.A.A.

West Virginia

Plant Manager-Expenditure Committee

Expenditure Committee

Baltimore

4401 Ridge Road, Baltimore, 21234

Baltimore

Baltimore

Baltimore

1972

1972

1972

1972

4401 Ridge Road, Baltimore, 21234

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288081

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 3 3 0

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Mary</u> MIDDLE <u>Anna</u> LAST <u>Jung</u> MARY ANNA JUNG			2a. DATE OF DEATH MONTH <u>10</u> DAY <u>7</u> YEAR <u>85</u>		2b. HOUR <u>1030</u> M
3. SEX <u>FEMALE</u>	4. RACE <u>WHITE</u>	5. DATE OF BIRTH MONTH <u>6</u> DAY <u>5</u> YEAR <u>14</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>71</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>PENNA.</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTO. CO.</u> MD.	
10. CITY OR TOWN OF DEATH <u>CATONSVILLE MD</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>BLAND-BRYANT N.H.</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>UNK.</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>UNK.</u>
13a. STATE <u>MD</u>	13b. COUNTY <u>BALTO</u>	13c. CITY OR TOWN <u>DUNDACK</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <u>6901 FENWAY RD. DUNDACK, MD 21221</u>	
14. FATHER'S NAME FIRST <u>BRECKENRIDGE</u> MIDDLE <u>ADOLPH</u> LAST <u>PROCTOR</u>		15. MOTHER'S MAIDEN NAME FIRST <u>PROCTOR</u> MIDDLE <u>ADOLPH</u> LAST <u>PROCTOR</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>	16b. SOCIAL SECURITY NO. <u>215-10-1072</u>	17. INFORMANT <u>CHART</u> ADDRESS <u>1040 Middleborough road 21221</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Acute Myocardial Infarct

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) Arteriosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

(c) Diabetes mellitus

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Obesity - Schizophrenia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>12-26-</u> 19 <u>84</u> to <u>10-7-</u> 19 <u>85</u> , that (1) (we) lost saw the deceased alive on <u>10-7-</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Cesar V. Caveno</u>		DEGREE <u>M.D.</u>	22c. DATE SIGNED <u>10-7-85</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CESAR V. CAVENO</u>		22e. ADDRESS <u>Spring Grove Hosp. Center</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>	23b. DATE <u>10-9-85</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Security Process</u>	23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Md.</u>
24. FUNERAL DIRECTOR NAME <u>Cremation Society of Md. Inc</u>		25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>OCT 10 1985</u>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the must be notified of once.

120683



289043

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 3 3 1

1 - FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Katherine B. KAHL			2a DATE OF DEATH MONTH DAY YEAR October 9, 1985		2b HOUR 12:15a M		
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Dec. 15, 1941		6 AGE (IN YEARS LAST BIRTHDAY) 43 YRS. MONTHS DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10 CITY OR TOWN OF DEATH Rossville 21237		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Sq. Hospital		12a USUAL OCCUPATION (17a USUAL OCCUPATION, IF WORKING)		12b KIND OF BUSINESS OR INDUSTRY Home	
13a STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Middle River		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Henry Zech		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Myers		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 219 38 9468	
17 INFORMANT Marvin Kahl, Husband		ADDRESS Same		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Breast Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (this hospital) attended the deceased from <u>October 5</u> , 19 <u>85</u> , to <u>October 9</u> , 19 <u>85</u> , that (we) last saw the deceased alive on <u>October 9</u> , 19 <u>85</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.							
22b SIGNATURE R K Mahoney MD		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 10/09/85	
22d PHYSICIAN'S NAME (TYPE OR PRINT) R K Mahoney, M.D.		22e ADDRESS 9000 Franklin Sq. Dr., 21237		23a BURIAL, CREMATION, REMOVAL (18a) Burial		23b DATE 10/12/85	
23c NAME OF CEMETERY OR CREMATORY Holly Hill Memorial Gardens		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.		24 FUNERAL HOME Bruzdzinski Funeral Home PA 1407 Old Eastern Ave		25 DATE REC'D BY REGISTRAR OCT 14 1985	
26 REGISTRAR'S SIGNATURE John Davidson		27 REGISTRAR'S SIGNATURE		28 REGISTRAR'S SIGNATURE		29 REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be placed in the container with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

BP

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[illegible]

298040

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
WILLIAM THOMAS KAISER, JR.			10 19 85			3:20A M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
MALE	WHITE	4 21 15	70 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						
Maryland	U.S.A.	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Arbutus	4315 Highview Avenue		Supervisor			Reveri Copper Co.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE		
Maryland	Baltimore	Arbutus	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			4315 Highview Avenue 21229		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST William T. Kais			FIRST MIDDLE LAST UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
NO			214-05-1784			Elizabeth C. Kaiser 4315 Highview Ave. 21229		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) _____
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }
DUE TO, OR AS A CONSEQUENCE OF (c) _____

Cardiovascular

Metastatic disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE	DEGREE	22c. DATE SIGNED	
<i>[Signature]</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	10-21-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		
Dr. M. AFZAL	9055 Chevrolet DR E-C Md.		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	10/22/85	Glen Haven Cemetery	Glen Burnie A.A. Maryland
24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR		
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229	OCT 23 1985		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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20% COTTON FIBER

CHIEFMAN BOW

282037

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5

2 7 3 3 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST AUDREY KAMINSKI		2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 2, 1985		2b. HOUR 12:50 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 20 1919	
6. AGE (IN YEARS LAST BIRTHDAY) 65		7. IF UNDER 1 YEAR MONTHS DAYS YRS		8. IF UNDER 24 HRS HOURS MIN YRS	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Linthicum		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 307 Jerome Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
12b. KIND OF BUSINESS OR INDUSTRY Home		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. CITY OR TOWN Baltimore	
13c. CITY OR TOWN Linthicum		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 307 Jerome Avenue 21090	
14. FATHER'S NAME FIRST MIDDLE LAST Frank BLACK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helena SEADERER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NUMBER 312-72-0753		17. INFORMANT ADDRESS Bernard S. Kaminski 307 Jerome Avenue		17. INFORMANT ADDRESS Bernard S. Kaminski 307 Jerome Avenue	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Pneumonia**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Alzheimer's dis.**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4 days**7 years**PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: **no**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (the hospital) attended the deceased from Jan. 19, 60 to Oct. 2, 1985 , that (I) (we) lost view the deceased alive on Oct. 1, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE Dr. Mass				DEGREE MD.		22c. DATE SIGNED Oct. 3, 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Mass				22e. ADDRESS 413 Nottingham Rd., 21229			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-5-85		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Mausoleum		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Avenue				25. DATE REC'D. BY REGISTRAR OCT 5 1985		25b. REGISTRAR'S SIGNATURE [Signature]	

285037

20% COTTON FIBER

MAILED

CHITRE & SONS LTD.

100% COTTON

100% COTTON

100% COTTON

283096

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 2 7 3 3 4
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Catherine V. Kammer			2a. DATE OF DEATH MONTH DAY YEAR Oct. 4, 1985		2b. HOUR A. M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 24, 1908		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN. 77		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.		
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6515 Frederick Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Reg. Nurse		12b. KIND OF BUSINESS OR INDUSTRY Nursing	
13a. STATE Md.			13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Ferdinand G. Kammer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine C. Fahey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT ADDRESS Cockeysville, Md. 21030. Mr. Harry G. Mullen-16 Flanders Ridge				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest Court DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Arteriosclerotic Heart Disease 20 years DUE TO, OR AS A CONSEQUENCE OF (c) 20 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Cancer Prostate								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Jan 1970 to 10/4 85 , that (I) (we) last saw the deceased alive on July 1984 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE James Nolan				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10/4/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NOLAN				22e. ADDRESS 1 Malvern Hill Rd Baltimore Md				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/7/85		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery-Baltimore, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE 21229		
24. FUNERAL DIRECTOR NAME Sterling Funeral Estate, P. A.				25a. DATE REC'D. BY REGISTRAR OCT 8 1985		25b. REGISTRAR'S SIGNATURE John L. ...		
26. ADDRESS 736 Edmondson Avenue; Catonsville, Md. 21228								

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the funeral director. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

228036

Memorandum for the Director

Subject: [Illegible]

Reference is made to [Illegible]



[Illegible text block containing several lines of typed information, possibly a summary or findings section.]

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[Illegible text block, likely the conclusion or recommendations section.]

301055

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Mrs. Helen Rosalie Karcz			2a DATE OF DEATH MONTH DAY YEAR October 22 1985			2b HOUR 10:45 PM				
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR August 15 1906		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10 CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland			13b COUNTY Baltimore		13c CITY OR TOWN Merrymount		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 8405 Merryview Road 21207	
14 FATHER'S NAME FIRST MIDDLE LAST Anthony Stackowska			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Stachowska							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-48-6041		17 DECEASED'S ADDRESS MISS. Adella Karcz 8405 Merryview Drive Baltimore Maryland		21207				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SEPTICAEemia, DEHYDRATION. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: CHRONIC RENAL FAILURE										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 10-18-85 to 10-22-85 , that (I) (we) lost saw the deceased alive on 10-22-85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE Purushottam Mitra					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c DATE SIGNED 10-22-85		
22d PHYSICIAN'S NAME (TYPE OR PRINT) PURUSHOTTAM MITRA					22e ADDRESS					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 10-25-85		23c NAME OF CEMETERY OR CREMATORY Lake View Memorial Park		23d LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Maryland			
24 FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc. ADDRESS 8728 Liberty Road Randallstown, Maryland 21133					25a DATE REC'D. BY REGISTRAR OCT 24 1985		25b REGISTRAR'S SIGNATURE John Davidson-Randall			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP.

290071

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 2 7 3 3 6
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SARAH KATZEN			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 13, 1985			2b. HOUR 3:30A.M.			
3 SEX FEMALE		4 RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR MAY 20, 1909		6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10 CITY OR TOWN OF DEATH PIKESVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PIKESVILLE NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. VISUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND					13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		
14 FATHER'S NAME FIRST MIDDLE LAST UNKNOWN					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-01-0353		17. NAME AND ADDRESS OF DECEASED ESTATE OF SARAH KATZEN c/o RABBI HERMAN NEUBERGER 401 YESHIVA LANE (21208)					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of breast with mets</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>year(s)</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 13, 1985</u> to <u>Oct 13, 1985</u> , that (I) (we) last saw the deceased alive on <u>Sept 25, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>David I. Miller</u> M.D.						22c. DATE SIGNED <u>10-13-85</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>David I Miller</u>	
22e. ADDRESS <u>10219 S. Delfield Rd. Baltimore, MD 21117</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10/13/85		23c. NAME OF CEMETERY OR CREMATORY HAR ZION TIFERETH ISRAEL ROSEDALE BALTO MD		23d. LOCATION CITY OR TOWN COUNTY STATE		
24 FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215						25a. DATE REC'D. BY REGISTRAR OCT 15 1985			

MEDICAL CERTIFICATION

BP

294090

FOR
1- STATE REGISTRAR
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

27337

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Charles Jacob Kemp								X		10/13/		19		85		4:00 P	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	White	April 19, 19		66 YRS.						10/ 15/		19		85			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.														Baltimore County, MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR WATER AND											
Baltimore County		1605 E. Cantwell Rd. Apt. E				Balto. County Foreman- Sewer											
13a. STATE		13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Baltimore		Balto. County		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1605 Cantwell Road Apt. E									
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME													
FIRST MIDDLE LAST				FIRST MIDDLE LAST													
David Duff Kemp				Nettie C. Ray													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS					
Yes				WW 11				214-16-3892				Mr. John S. Kemp					
								3203 Elmo Drive				Randallstown, MD. 21133					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Fatty Cirrhosis of Liver																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																	
(b) DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?					
												HEAD & ABDO. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
				HOUR A.M. MONTH DAY YEAR													
				P.M. 19													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION									
								STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above and on inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined manner <input type="checkbox"/>																	
TITLE (SPECIFY)																	
M.D. Assistant MEDICAL EXAMINER																	
DATE SIGNED 10/16/85																	
ACTUAL SIGNATURE																	
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
Burial				10-18-85				Lake View Memorial Park				Sykesville Carroll Maryland					
24. FUNERAL DIRECTOR NAME Loring Byers, Funeral Directors, Inc. ADDRESS 8728 Liberty Road Randallstown, MD. 21133																	
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE																	
OCT 17 1985																	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH PAGES 1, 2, AND 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
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297148

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Casimir F. Keydash				2a. DATE OF DEATH MONTH DAY YEAR 10 17 85		2b. HOUR 945 PM	
3 SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sep. 6, 1906		6 AGE (IN YEARS LAST BIRTHDAY) 79 years	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10 CITY OR TOWN OF DEATH Towson, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stella Moris Hospice				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Catholic Priest	
13a. STATE MD.		13b. COUNTY Balto.		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Casimir Keydash				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Milinauskas			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO WWW2		17. INFORMANT ADDRESS Family records			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recent Stroke DUE TO, OR AS A CONSEQUENCE OF (b) Advanced Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR PM 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/16 , 19 85 , to 10/17 , 19 85 , that (I) (we) last saw the deceased alive on 10/17 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Eddie Nakhuda		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/17/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS Dulaney Valley Rd. Towson Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 10/21/85		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, MD.	
24. FUNERAL DIRECTOR NAME ADDRESS Evans Chapel of Chimes 2325 York Road				25a. DATE REC'D. BY REGISTRAR OCT 22 1985		25b. REGISTRAR'S SIGNATURE L. A. Anderson-Pandora	

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

B 5 2 7 3 3 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EDWARD A. KIEFER		2a. DATE OF DEATH MONTH DAY YEAR 10. 13. 85		2b. HOUR 11.05^{PM}	
3. SEX MALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11- 27- 16		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Edgemere	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3106 Grace Road 21219
14. FATHER'S NAME FIRST MIDDLE LAST Louis Kiefer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Magdalene Ager			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> OR UNKNOWN <input type="checkbox"/> IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 213-07-1623		17. INFORMANT ADDRESS Eileen L. Kiefer 3106 Grace Road 21219	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinoma Pancreas with metastasis. DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Acute tubular necrosis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/11/85 to 10/13/85 , that (I) (we) lost saw the deceased alive on 10/13/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Purneshottam Mitra		DEGREE		22c. DATE SIGNED 10.13.85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PURUSHOTTAM MITRA		22e. ADDRESS HOSP.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10-14-85		23c. NAME OF CEMETERY OR CREMATORY Westview Memorial	
23d. LOCATION CITY OR TOWN COUNTY STATE Westview, Balto. Co., Md.		24. FUNERAL DIRECTOR NAME ADDRESS Charles S. Zeiler & Son Inc. 901 S. Conkling St.		25a. DATE REC'D. BY REGISTRAR OCT 15 1985	
25b. REGISTRAR'S SIGNATURE na waldson					

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1 - FOR
STATE
REGISTRAR

REG. NO.

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|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ERNEST Theodore KIRBY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Oct. 9, 85 | | 2b. HOUR
5:55 A |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
1-13-31 | 6. AGE (IN YEARS LAST BIRTHDAY)
54 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
California | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | | |
| 10. CITY OR TOWN OF DEATH
Randallstown | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Baltimore County General Hospital | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
College Professor | | 12b. KIND OF BUSINESS OR INDUSTRY
UMBC | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE
Maryland | | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Woodlawn | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 13e. STREET ADDRESS / ZIP CODE
7404 Lasada Dr. Apt 1B 21207 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Stanley John Kirby | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Evelyn Marie Kuhs | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
Korea 085-24-6260 | | 17. INFORMANT
New York, NY ADDRESS 10012 Apt. 8C
Michael Kirby 1 Washington Square Village | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Cirrhosis of the liver
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept. 25, 1985 to Oct. 9, 1985 , that (I) (we) lost
saw the deceased alive on Oct. 9, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Sharon Pourmotabbed, M.D. | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
10-9-85 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GHASSEM POURMOTABBED | | | 22e. ADDRESS
Balt. Co. Gen. Hospital | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | 23b. DATE
10-10-85 | 23c. NAME OF CEMETERY OR CREMATORY
Westview Crematory | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Catonsville Baltimore MD | | |
| 24. FUNERAL DIRECTOR
NAME
Loring Byers Funeral Directors, Inc.
ADDRESS
Randallstown, MD 21133 8728 Liberty Rd. | | | 25a. DATE REC'D. BY REGISTRAR
OCT 15 1985
25b. REGISTRAR'S SIGNATURE
[Signature] | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | |
| | | LEONA PEARL KIRKPATRICK | | | | OCTOBER 28 1985 | | | | 1:45 A.M. | |
| 1. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| FEMALE | | WHITE | | MAY 25 1909 | | 76 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MARYLAND | | USA | | | | BALTIMORE COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | 7407 GREENBANK ROAD | | | | | | NURSE | | HOSPITAL | |
| 13a. STATE | | 13b. CITY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | |
| MD. | | BALTIMORE | | BALTIMORE | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 7407 GREENBANK RD. 21220 | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | ADDRESS | | | |
| WALTER PHILLIPS | | | | CARRIE CUTTER | | | | RT. 1, BOX 162 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| NO | | | | 212-40-4220 | | HAZEL BEALE (SISTER) HEDGESVILLE, W. VA. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Metastatic breast & neck cancer</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| (b) <u>Progressive emphysema 2nd to 3rd</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| | | | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| <u>S. Milner MD</u> | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 10/29/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| DR. SHELDON MILNER | | | | FRANKLIN SQUARE HOSPITAL | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| BURIAL | | | | 10/30/85 | | BALTIMORE CEMETERY | | BALTIMORE MD. | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| NAME SCHIMUNEK FUNERAL HOME, INC.
3331 Brehms Lane, Balto, Md. 21213 | | | | | | NOV 01 1985 | | <u>Janet Davidson</u> | | | |

303020



288113

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JOSEPHINE SHRIVER KLEMM | | | 2a. DATE OF DEATH
MONTH DAY YEAR
October 8, 1985 | | 2b. HOUR
4:45 M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 6, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH
Parkville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Perring Parkway Nursing Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
MD | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Towson | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
8025 York Road, 21204 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Shriver | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
(Unknown) | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
212 03 9522 | | 17. INFORMANT
ADDRESS
One Smeton Place
Mr. Samuel J. Oddo Towson, MD 21204 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>disease.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/29</u> 19 <u>82</u> , to <u>10-8</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>10/8</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>GRA CIFI V. PATRICIO</u> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>10/8/85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>GRA CIFI V. PATRICIO</u> | | 22e. ADDRESS
Perring Pkwy. Nursing Home
Dr. G. V. Patricio, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
10/11/85 | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., MD | |
| 24. FUNERAL DIRECTOR
NAME
Henry W. Jenkins & Sons Co.
4905 York Road, Balto., MD | | | 25a. DATE REC'D. BY REGISTRAR
OCT 10 1985 | | |
| 25b. REGISTRAR'S SIGNATURE
<u>Jake Gordon-Rendell</u> | | | | | |

MEDICAL CERTIFICATION

35 90 35 35 11

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be immediately filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the local coroner must be notified at once.

BP

290017

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|--|--|---|--|--|--|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) HALL Marvin Klenk | | | 2a. DATE OF DEATH
MONTH 10 DAY 11 YEAR 85 | | | 2b. HOUR
6:12 AM | | | | | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH 12 DAY 21 YEAR 13 | | 6 AGE (IN YEARS LAST BIRTHDAY)
71 YRS | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS
HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO CO MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St Joseph Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
President | | 12b. KIND OF BUSINESS OR INDUSTRY
Construction | | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
6401 Bellona Ave. 21212 | | |
| 14. FATHER'S NAME
FIRST Fernand MIDDLE Klenk LAST Klenk | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Loretta MIDDLE Hall LAST Hall | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
220-01-3350 | | 17. INFORMANT
1618 Myramby Rd.
Richard D. Bussey Towson, Md. 21204 | | | | | | |

| | | | |
|---|--|---|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ADENOCARCINOMA, Gastric, metastatic
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
8 mos | |
|---|--|---|--|

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
Agnarion pneumonia | | | | | | | |
| 19a. DATE OF OPERATION
April 85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Gastric obstruction | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME - STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10-8 , 19 85 , to 10-11 , 19 85 , that <input checked="" type="checkbox"/> (we) lost
saw the deceased alive on 10-11 , 19 85 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated
above, <input checked="" type="checkbox"/> (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
Wm Carl Ebeling MD | | | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
William C. Ebeling, M.D. | | | | | | 22e. ADDRESS
7620 YORK ROAD TOWSON MD 21204 | |

| | | | | | | | |
|---|--|-----------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
SPEC Burial | | 23b. DATE
Oct. 14, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley | | 23d. LOCATION
Timonium, Baltimore co., Md. | |
| 24 FUNERAL DIRECTOR
NAME Mitchell-Wiedefeld Home, Inc. ADDRESS 6500 York Rd. Balto., Md. 21212 | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 15 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

710002

RECEIVED

NOV 21 1964



282067

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) EMANUEL KNOX | | | 2a. DATE OF DEATH
MONTH DAY YEAR
10 05 85 | | | 2b. HOUR
2:50 P.M. | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
02 11 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
1 1 1 1 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Va. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Balto Co. General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Retired | |
| 13a. STATE
Md | | 13b. COUNTY
Balto | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2413 Keyworth Avenue 21215 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James E. Knox | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Maggie J. Smith | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes | | | |
| 17. SOCIAL SECURITY NO.
218-03-9164 | | | 17. INFORMANT Sally Knox ADDRESS
(Hospital Record) 2413 Keyworth Ave | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Sepsis
DUE TO, OR AS A CONSEQUENCE OF
(c) Obstructive Pulmonary Disease
(3) Invasive CaC Distant Metastasis | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
few days - about today | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10
metabolic Acidosis 2° to sepsis | | | | | | | | | |
| 19a. DATE OF OPERATION
10-05-85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
10-05-85 | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-05-85 to 10-05-85 , that (I) (we) last saw the deceased alive on 10-05-85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Suresh Gupta | | | | DEGREE
MD | | | | 22c. DATE SIGNED
10-05-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SURESH K GUPTA, MD | | | | 22e. ADDRESS
BCGM old courts Road Balto Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
10/10/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest Vet | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Owings Mills Md | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
William C. March F/H Inc West 4300 Wabash Ave | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 7 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Anderson | | | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the physician must state the medical cause of death.

William C. March F/H Inc West 4300 Wabash Ave

Burial 06410200 Garrison Forest Vet Owings Mills Md

James
Yo

E. Knox

Maddie
2411 Knox T.

2413 Kedmont Ave
Smith

X

No.

Count 3

51512

290012

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Emerson W. Koons | | | 2a. DATE OF DEATH
MONTH 10 DAY 14 YEAR 85 | | 2b. HOUR
9A M |
| 3. SEX
M | 4. RACE
Cauc | 5. DATE OF BIRTH
MONTH 7 DAY 12 YEAR 03 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
Towson | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
STELLA MARIS Hospice | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ass't Mgr. | | 12b. KIND OF BUSINESS OR INDUSTRY
Life Insurance |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md. 13b. COUNTY Baltimore 13c. CITY OR TOWN Timonium | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
11076 Greenspring Ave. -21093 |
| 14. FATHER'S NAME
FIRST William MIDDLE Koons LAST | | | 15. MOTHER'S MAIDEN NAME
FIRST Ella F. MIDDLE Wilhelm LAST | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215 10 9816 | | 17. INFORMANT ADDRESS
3843 Reinhardt Rd.
Mr. Kenneth C. Koons, Sr. Westminster, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BLADDER CANCER WITH LIVER
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) AND ABDOMINAL METASTASIS
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10.1.85 to 10.14.85 , that (I) (we) lost
saw the deceased alive on 10.14.85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
EDDIE NAKHUDA | | DEGREE
M.D. | | 22c. DATE SIGNED
10.14.85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EDDIE NAKHUDA | | 22e. ADDRESS
STELLA MARIS Hospice | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
10/17/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge Cem. | |
| 23d. LOCATION
CITY OR TOWN
Baltimore, Md. | | COUNTY
Baltimore | | STATE
Md. | |
| 24. FUNERAL DIRECTOR
NAME
MITCHELL-WIEDEFELD HOME, INC. ADDRESS
6500 York Rd. | | | 25a. DATE REC'D. BY REGISTRAR
OCT 15 1985 | | |
| 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1



UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

304135

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 2 7 3 4 6
CERTIFICATE OF DEATH

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
ANNIE D. KRAUSE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
October 28, 1985 | | 2b. HOUR
6:30A M |
| 3. SEX
Female | 4 RACE
White | 5 DATE OF BIRTH
MONTH DAY YEAR
Jan 18 1890 | | 6 AGE (IN YEARS LAST BIRTHDAY)
95 95 YRS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | | |
| 10 CITY OR TOWN OF DEATH
Pikesville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Pikesville Nursing Center | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | 12b KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a STATE
Maryland | | | 13b COUNTY
Howard | 13c CITY OR TOWN
Ellicott City | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
August Kersten | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Katherine Mary Super | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | |
| 16b SOCIAL SECURITY NO.
214-54-4657 | | 17 INFORMANT
Catherine Krause | | Same as # 13 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Cryptogenic Heart failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 30</u> , 19 <u>85</u> , to <u>Oct 28</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>Sept 30</u> , 19 <u>85</u> , and that (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Harold B. Bob M.D.</u> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
10/28/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Harold B. Bob M.D. | | 22e. ADDRESS
7220 Park Heights Avenue, Baltimore, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
10/30/85 | 23c. NAME OF CEMETERY OR CREMATORY
St. Pauls Lutheran Cemetery - Fulton | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Howard Maryland |
| 24. FUNERAL DIRECTOR
Leroy M. & Russell C. Witzke Funeral Homes P.A.
1630 Edmondson Avenue, Catonsville, MD. 21228 | | | 25a. DATE REC'D. BY REGISTRAR
OCT 29 1985 | | |
| | | | 25b. REGISTRAR'S SIGNATURE
<u>John A. ...</u> | | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of this.

201401



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282041

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 3 4 7

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|--|---|---|--|-----------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
GERTRUDE I KRISTON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
OCT 2, 1985 | | 2b. HOUR
10 30 PM | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
SEPT 16 1921 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
64 | | 7a. BIRTHPLACE (STATE OR FOREIGN + COUNTRY)
USA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
REISTERSTOWN | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
38 MERIAM CT. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
COMP OPERATOR | | |
| 12b. KIND OF BUSINESS OR INDUSTRY
SEC SEC | | 13a. STATE
MD | | 13b. COUNTY
REISTERSTOWN | | |
| 13c. CITY OR TOWN
REISTERSTOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
38 MERIAM CT. 21136 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ISSAC H KNIGHTON | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
GERTRUDE I DOBSON | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF YES, GIVE WAR OR DATES)
YES WW II | | 16b. SOCIAL SECURITY NO.
222-10-7624 | | 17. INFORMANT
ADDRESS
EDWARD R. KRISTON MAYBIN CLARE 43 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hepatic Failure
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Gallbladder
DUE TO, OR AS A CONSEQUENCE OF (c) 4 mo. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/19 , 19 85 , to 10/2 , 19 85 , that (I) (we) lost
saw the deceased alive on 8/29 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Wm C Waterfield MD | | DEGREE
MD | | 22c. DATE SIGNED
10/3/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Wm C Waterfield MD | | 22e. ADDRESS
St Agnes Hospital
900 Caton Ave Balt Md 21229 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)
CREMATION | | 23b. DATE
10/4/85 | | 23c. NAME OF CEMETERY OR CREMATORY
WESTVIEW MEM CATHOLIC | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
MD | | 24. FUNERAL DIRECTOR
NAME ADDRESS
WEBER FUNERAL HOME EDMONDSON AVE 5311 | | | | |
| 25a. DATE REC'D. BY REGISTRAR
OCT 7 1985 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be forwarded within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use at the burial/transfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy performed.

BP

295135

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|----------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
HENRY KROEGER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
October 16, 1985 | | 2b. HOUR
4:30 PM | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 8, 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS MONTHS DAYS HOURS MIN.
79 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Germany | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH
Arbutus | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5000 Tulip Avenue | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Painter | |
| 13a. STATE
MD | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Arbutus | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Johann Kroeger | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Dreyel | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | |
| 17. INFORMANT
Mr. Chris Wright, | | ADDRESS
Same | | 18. SOCIAL SECURITY NO.
170 24 4550 | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

carcinoma of the pancreasAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**~ 1 month**

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

Diabetes Mellitus

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION
N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
N/A | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
N/A | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
N/A | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
N/A | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>
N/A | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
N/A | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
N/A | | | |
| 22a. I certify that (a) this hospital attended the deceased from 5/13 , 19 85 , to 10-16 , 19 85 , that (b) (we) last saw the deceased on 10/15/85 , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above (and did not see the body after death). | | | | | | | |
| 22b. SIGNATURE
Charles R. Graham | | | | DEGREE
MD | | 22c. DATE SIGNED
10-17-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Charles Graham, MD | | | | 22e. ADDRESS
405 Frederick Avenue, Balto., MD | | | |

| | | | | | | | |
|--|--|------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal-Burial | | 23b. DATE
10/17/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Forest Hills | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Philadelphia, PA | |
| 24. FUNERAL DIRECTOR
NAME
Henry W. Jenkins & Sons Co. | | | | | | 25a. DATE RECEIVED BY REGISTRAR
OCT 18 1985 | |
| 4905 y York Road Balto., MD 21212 | | | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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REPLY

15, 1985

Wines

Wines

USA

Germans

various

various

Baltimore, Maryland

MD

Prosecco

Johann

170 BA 4550 Mr. Charles White, Jr.

no

Charles White, Jr.

no

1st. Charles White, Jr.

Dr. Charles White, Jr.

Philadelphia, PA

Removal-Budget 10-17-85 Forest Hills

Frank W. Jones & Son, Co.

405 York Road, Baltimore, MD 21212

296044

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 3 4 9

REG. NO.

| | | | | | | | | |
|---|--|---|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Catherine Martha KUCHARSKI | | | 2a. DATE OF DEATH
MONTH DAY YEAR
October 18, 1985 | | | 2b. HOUR
4:55
P.M. | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 29 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY)
92
YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore, MD | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County
MD. | | |
| 10. CITY OR TOWN OF DEATH
Rossville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Franklin Square Hospital | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
Fed. Gov't. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Dundalk | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Herman Schindle | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Katherine A. Unknown | | 13d. STREET ADDRESS / ZIP CODE
113 Williams Ave. 21222 | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
— | | 17. INFORMANT ADDRESS
Mary Frey 7128 Railway Ave. 21222 | | | | |

| | | | |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory ARrest | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Sepsis | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

History of Cerebrovascular Accident

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from October 17, 19 85, to October 18, 19 85, that (we) last saw the deceased alive on October 18, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
RK Mahoney | | | | DEGREE
MD | | 22c. DATE SIGNED
10-18-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RK Mahoney | | | | 22e. ADDRESS
9000 Franklin Square Drive Baltimore, MD 21237 | | | |

| | | | | | | | |
|--|--|-------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
10/21/1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore MD | |
| 24. FUNERAL DIRECTOR
NAME
Walter Brooks Bradley, Inc. Balto., MD 21222 | | | | 25. DATE RECEIVED BY REGISTRAR
OCT 21 1985 | | 25b. REGISTRAR'S SIGNATURE
The Honorable [Signature] | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

119323

COLOMBIA

W/A
1/1/19



297108

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 7 3 5 0

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Andrew H. Kunkowski | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
10 20 85 | | | | 2b. HOUR
8:30am | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 10 97 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. Co. MD. | | | |
| 10. CITY OR TOWN OF DEATH
Essex | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Riverview Nursing Centre, Inc. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Medical Doctor | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank Kunkowski | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Valerie Glinka | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWI | | 17. INFORMANT
ADDRESS Delmar, Md. 21875
Frank A.P. Kunkowski, Box 133 Rt. 3 | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Chronic Myelogenous Leukemia
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 19 , 19 84 , to Oct. 20 , 19 85 , that (I) (we) last saw the deceased alive on Oct 17 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
M. Rainess | | | | DEGREE M.D.
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
10/20/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MORRIS RAINESS, M.D. | | | | 22e. ADDRESS
1105 OLD EASTERN AVE. Balto., Md. 21221 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
10-23-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck, Inc., 5305 Harford Rd. | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 22 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Burden Spence | | | |

MEDICAL CERTIFICATION

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BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be received within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and a copy filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

